NAVAL POSTGRADUATE SCHOOL

Monterey, California

ORGANIZATIONAL STRUCTURE AND OPERATION OF CHAMPUS

by

Leland Maassen

and

David Whipple

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Prepared for:
Chief of Naval Operations
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NAVAL POSTGRADUATE SCHOOL
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Rear Admiral Isham Linder
Superintendent

Jack R. Borsting
Provost

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This report outlines the Organizational structure and operation of the OCHAMPUS (The Office of the Civilian Health and Medical Program For The Uniformed Services) and offers some evaluation of its management. Procedures used by the several levels of management are reviewed and examined.

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INTRODUCTION

CHAMPUS is nearing the end of its eighteenth year of existence. In that period of time over $3,095,000,000 has been paid to the program's several fiscal intermediaries. Of that amount, $1,827,000,000 was expended prior to the end of Fiscal Year 1971. The remainder, some $1,268,000,000 was expended in the next three fiscal years. In Calendar Year 1967, dependents of active duty and retired members and retired military personnel submitted approximately 178,000 claims for hospital and professional services. By the end of Calendar Year 1974 the total number of claims processed for that category had risen to more than 2,814,000. By the end of July 1974, the total number of claims processed over the life of the CHAMPUS Program exceeded 20,727,000.

Most of the senior military and civilian officials of the Department of Defense consider the CHAMPUS Program an important factor in the recruiting and retention of career members of the Armed Forces. With the advent of the "All Volunteer Forces" concept its importance has become even greater. On the other hand, critics of the program claim that it is mismanaged, that people take advantage of it, and that the program is too costly. They claim, and rightly so, that the average sailor, soldier, or airman does not know about the program. In addition, Congress has taken an interest in the CHAMPUS Program. This interest, prompted by the

rapidly rising costs of health care, has placed the program in the so-called "limelight."

In the present report the organization of the Office of CHAMPUS is reviewed to determine the interactions of that office with the Department of Defense, the fiscal administrators, and the beneficiaries. In addition the claims processing procedures used by major fiscal intermediaries and OCHAMPUS are described. This compilation of facts in one place should facilitate informed evaluation of various proposals to upgrade or modify management controls.

THE CHAMPUS ORGANIZATION

The administrative functions of the Dependent's Medical Care Program had been, since its inception, assigned to the Office of The Surgeon General of the Army. In late 1971, however, the Congress expressed its displeasure at the manner in which the program administration was being handled. They directed that the Office of the Secretary of Defense should take a more active role in that function. As a result, the Assistant Secretary of Defense (Health and Environment) was named to direct the Dependents Medical Care Program. Although that office became the titular head of the program, the actual administration continued to be accomplished by an Army Medical Officer from the Army Surgeon General's office.

The Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) is physically located on the grounds of the Fitzsimmons Army Medical Center, Denver, Colorado. It is currently situated in two converted barracks-type buildings. The OCHAMPUS staff is primarily composed of civilian personnel although there are eighteen military officers currently assigned to duty there. A memorandum from Deputy Secretary of Defense [Ref. 1] dated 4 December 1974 on the subject of CHAMPUS stated that these military billets, six Army, five Navy (includes one Coast Guard officer), and seven Air Force, would be civilianized. It is anticipated by the Acting Deputy Director that the civilianization will

be accomplished through normal attrition, that is, as the military officer assigned to the position is detached, the replacement will be a civilian.

In the same memorandum it was specifically stated that "The Director of OCHAMPUS shall be a civilian selected by the Assistant Secretary of Defense (Health and Environment)." The last designated Director of OCHAMPUS departed the command in mid-1974. Since that time an Air Force Medical Service Corps Colonel has been Acting Director and the Acting Deputy Director has been a Navy Medical Service Corps Captain. The civilian Director of OCHAMPUS, when named, is expected to be given a Civil Service GS-17 grade.

Prior to 1 July 1972, the Director of OCHAMPUS reported directly to the Surgeon General of the Army who, in turn, reported, for CHAMPUS related matters, to the Assistant Secretary of Defense (Health and Environment). The present chain of command is direct to OASD(H&E). It is direct except that OASD has established an Office of CHAMPUS Policy to which the Director of OCHAMPUS actually reports for most situations. The exception to this reporting path relates to the flow of funds. The funds used for the CHAMPUS Program previously came from the user services, i.e., the Army, Navy, Air Force. Now that the CHAMPUS appropriation is one of a few monitored and controlled directly by DOD, its funds come to OCHAMPUS from the Office of the Assistant Secretary of Defense (Administration).

As can be seen from the OCHAMPUS Table of Organization, Exhibit 1, the Director of OCHAMPUS has five offices which report to him in an advisory capacity. He also has four Directorates which carry out the operational aspects of the CHAMPUS Program [Ref. 2]

A. OFFICE OF THE MEDICAL AND THE DENTAL ADVISOR

These offices provide advisory services on extended care and handicapped treatment cases. They also advise the Director on, and review performance of, Utilization and Peer Review activities of CHAMPUS contractors. They maintain contact through the respective professional medical and dental staffs that the contractors maintain.

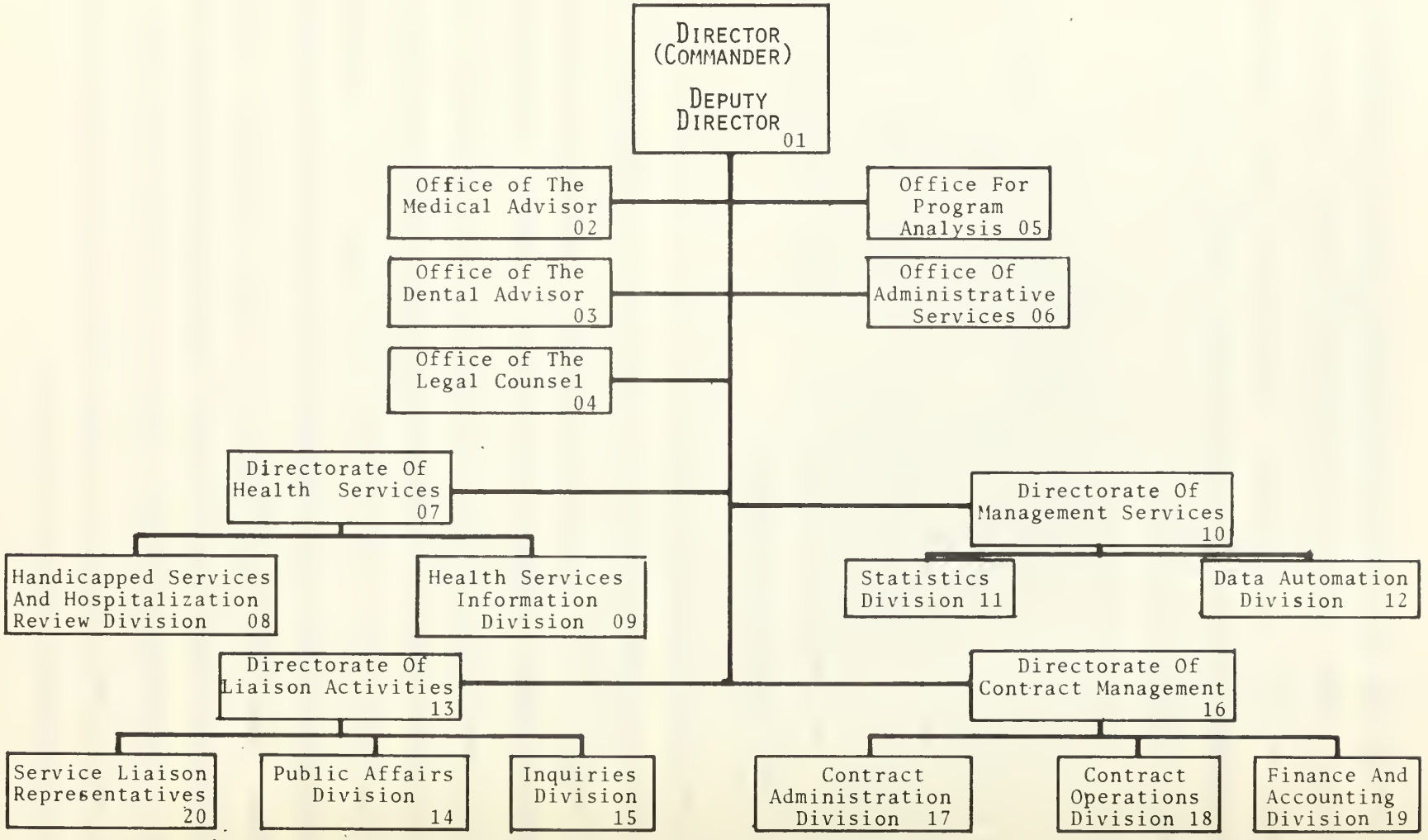
B. OFFICE OF THE LEGAL COUNSEL

The Legal Counsel examines, for legal sufficiency, all contracts with fiscal administrators for hospital and physicians' services. These examinations include all modifications, supplementary agreements, advance payment agreements, termination notices and all related contracting and procurement documentation. He also insures compliance with all applicable provisions of law, the Armed Services Procurement Regulations, and all procurement directives of higher authority. He advises the Director on all legal questions involving interpretations and monitors cases involving suspicion of fraud. He represents the Director in all legal matters requiring coordination with other federal agencies.

EXHIBIT 1

OFFICE FOR THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

(OCHAMPUS)



C. OFFICE FOR PROGRAM ANALYSIS

This office is the primary study group for the CHAMPUS Program. It is tasked with ongoing investigations of policies and procedures of the program with an objective of providing optimum service to the program beneficiaries at the minimum cost to the government.

D. OFFICE OF ADMINISTRATIVE SERVICE

This office provides logistic and administrative support for OCHAMPUS staff entities. The General Services Branch provides mail and messenger services and processes all incoming and outgoing correspondence. This branch also operates the records management program, carries out the supply functions for the command, and arranges for the maintenance of equipment and the OCHAMPUS buildings. The Reproduction and Housekeeping Branch provides all of the reproduction services to the command and obtains the necessary janitorial services for the OCHAMPUS buildings. The Stenographic Branch provides stenographic and clerical services to the command. They have recently installed a word processing system which involves a telephonic-call-in dictation machine. The tapes from these machines are transcribed by typists on magnetic cards which are then used to prepare smooth originals. This system allows the on-site inspectors to phone in their reports from a hotel room while the information is fresh on their mind. By the time they arrive back at OCHAMPUS, the finished report is on their desk ready for their signature.

E. DIRECTORATE OF HEALTH SERVICES

This Directorate is primarily concerned with the benefits available under the Program for the Handicapped. The Handicapped Services and Hospitalization Review Division acts on claims and requests for benefits for patients with moderate and severe mental retardation and for patients with serious physical handicaps, other than those of a dental nature. It reviews and approves or disapproves applications for extended hospitalization in excess of 90 days. Such cases involve patients with a diagnosis of some type of chronic condition, or a nervous, mental, or emotional disorder which falls under the provisions of the Basic CHAMPUS Program.

The Health Resources Information Division maintains a registry of information, including location, cost, and services provided for the use of handicapped children and other persons requiring specialized care. Sponsors, upon request, can obtain information on specialized care facilities for a given area which can provide the specific care required for an eligible dependent. This division also conducts on-site evaluations of the specialized care institutions to investigate complaints, to ascertain the quality and appropriateness of care, to ascertain the adequacy of staff and plant, and to insure compliance with pertinent lawas and accreditation standards.

F. DIRECTORATE OF MANAGEMENT SERVICES

The Management Services Directorate acts as a Management Information Systems Office and provides management information on a timely basis to all managerial elements of the OCHAMPUS staff. The Statistics Division provides statistical analysis of available data and recommends reporting formats for planning and reporting purposes. This division also makes recommendations concerning the inclusion of those items of data considered as essential for the OCHAMPUS data base. The Data Automation Division, through its Systems Design Branch, designs data automation systems and writes and maintains all of the OCHAMPUS computer programs. The Design Branch also performs feasibility-of-automation studies for various OCHAMPUS elements. The Computer Operations Branch operates the IBM 360/30 computer and peripheral equipment. It provides keypunch support, maintains input and output controls, and manages the computer tape library. This last function entails the inventory control of approximately 1,400 reels of taped programs and data.

G. DIRECTORATE OF LIAISON ACTIVITIES

This Directorate is charged with the development of an ongoing program of providing up-to-date CHAMPUS Program information to beneficiaries, to providers, to fiscal administrators, to hospital contractors, and to the several uniformed services. It also investigates and responds to complaints,

inquiries, and requests for assistance. The Service Liaison Representatives, a division of this Directorate, maintain liaison between OCHAMPUS and their respective services. They represent their service's interest to OCHAMPUS and advise and assist CHAMPUS Advisors and Health Care Counselors. They also provide assistance to other elements of the OCHAMPUS staff in handling inquiries, complaints, and requests. These representatives prepare special studies for their respective services when required or directed to do so.

The Inquiries Division's primary function is to investigate and respond to complaints and requests for information received from all sources. Another one of their functions is to submit requests to the services for eligibility determinations in questionable cases and to provide to fiscal administrators and sources of care all information concerning terminations of eligibility. The Public Affairs Division, in cooperation with the DOD information agencies, develops and manages a CHAMPUS information program. This program provides information on CHAMPUS benefits and eligibility requirements to all interested persons. They also recommend and coordinate public appearances by OCHAMPUS staff members and prepare or assist in the preparation of the member's speeches. They provide clearance for all other speeches and articles prepared by staff members and coordinate the presentation of CHAMPUS exhibits at national and local conventions.

H. DIRECTORATE OF CONTRACT MANAGEMENT

The Contract Management Directorate is responsible for all matters pertaining to contracts, except for legal matters. The Director of Contract Management exercises authority as the OCHAMPUS Contracting Officer for the United States Government. The Contract Administration Division has as its primary responsibility the administration of contracts, the development of workload data, budget estimates, and the representation of OCHAMPUS on all financial matters. They conduct on-site reviews of contractor operations. In this function they are primarily concerned with the adherence to established policy and the adequacy of service. They also monitor contractor operations through reviews of monthly claims activity reports.

The Contract Operations Division maintains liaison with the contractors, advises them on matters of policy and procedure, and performs monthly audits on selective samples of claims paid to determine accuracy of the contractor's claims processing procedures. This last function is accomplished with the assistance of the OCHAMPUS computer which generates, randomly, a series of claims numbers. The contractor is notified of these numbers and is requested to send the hard-copy claims to OCHAMPUS for review. This division also verifies contractor invoices prior to payment. They also maintain liaison with several associations and agencies which are involved in prepayment drug plans and perform administrative, consultative, and advisory work in the administration of the CHAMPUS drug program.

The Finance and Accounting Division certifies disbursement vouchers, controls all funds, maintains journals and ledgers, and prepares the financial reports. The actual operations of this division will be discussed more fully in a later section.

CLAIMS PROCESSING - FISCAL ADMINISTRATORS

A beneficiary's first contact with the CHAMPUS system occurs when they present themselves for treatment to a participating, qualified provider. The beneficiary presents the provider with a copy of DD Form 1251, Statement of Non-Availability, issued by the local military medical facility if they are seeking inpatient care [Ref. 3]. In return, the provider, depending on the type of care being provided, has the beneficiary complete applicable portions of one of the following forms:

a. DA 1863-1, Request for CHAMPUS Payment - Hospitals (Exhibit 2).

b. DA 1863-2, Request for CHAMPUS Payment - Other Than Hospitals (Exhibit 3).

c. DA 1863-3, Request for CHAMPUS Payment - Program for the Handicapped (Exhibit 4).

d. DA 1863-4, Request for CHAMPUS Payment - Pharmacies (Exhibit 5).

The beneficiary is responsible for the completion of items one through thirteen on these forms. Items one through six pertain to patient identification data including identification card number and the effective beginning and ending dates for eligibility. Items seven through twelve pertain to the identification and duty station of the service member. Item thirteen is the certification that the preceding items are

EXHIBIT 2-A

SERVICES AND/OR SUPPLIES PROVIDED BY CIVILIAN HOSPITALS

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

SEE INSTRUCTIONS ON REVERSE

SECTION I *(To be completed by patient or other responsible family member. Please print or type)*

PATIENT DATA

1 NAME *(last, first, middle initial)*

2. DATE OF BIRTH

3 ADDRESS *(Include Zip Code)*

4 PATIENT IS A *(Check one)*

☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE

5 IDENTIFICATION CARD *(DD Form 1173, DD Form 2 or PHS Form 1866-3)*

CARD NO

EFFECTIVE DATE — MONTH | DAY | YEAR

EXPIRATION DATE — MONTH | DAY | YEAR

6 BASIS FOR CARE - ACTIVE DUTY DEPENDENTS ONLY *(Check One)*

☐ (1) RESIDING APART FROM SPONSOR ☐ (2) RESIDING WITH SPONSOR DD FORM 1251 ATTACHED ☐ (3) OUTPATIENT

☐ (4) OTHER *(Specify)*

SERVICE MEMBER DATA

7 NAME OF SPONSOR *(last, first, middle initial)*

8. SERVICE NUMBER OR SOCIAL SECURITY NUMBER *(as applicable)*

9. GRADE

10. ORGANIZATION AND DUTY STATION *(Home Port for Ships)* *(Address for Retired)*

11. SPONSOR'S OR RETIREE'S BRANCH OF SERVICE

☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN

☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA

12 STATUS

☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

13 CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.

If a RETIRED MEMBER or dependent of a retired or deceased member, I certify that to the best of my knowledge and belief, that *(Check appropriate box)* *(Delete portion in parenthesis not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service, or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment, however the particular benefits claimed on this form are not payable under the other plan.

Name (print or type) _____ (Relationship to Patient) _____ Date _____ Signature _____

SECTION II *(To be completed by Source of Care)*

14 NAME AND ADDRESS OF HOSPITAL *(Include Zip Code)*

15 CIVILIAN SOURCE LOCATION CODE

16. THIS STATEMENT CONSTITUTES

☐ (1) A COMPLETE BILLING

OR PARTIAL BILLING *(Check appropriate box)*

☐ (2) INITIAL STATEMENT ☐ (3) INTERIM STATEMENT ☐ (4) FINAL STATEMENT

21 NAME OF ATTENDING OR ADMITTING PHYSICIAN OR DENTIST

17. HOSPITAL SERVICES

☐ (1) INPATIENT ☐ (2) OUTPATIENT

18. DISPOSITION OF PATIENT

☐ (1) REMAINING ☐ (2) DISCHARGED ☐ (3) DECEASED

19. INCLUSIVE DATES OF CARE

FROM — MONTH | DAY | YEAR — TO — MONTH | DAY | YEAR

20 NOSPITAL DAYS THIS STATEMENT

22 DIAGNOSIS *(Use standard nomenclature)*

23. INTL STAT CLASS

24. 12-BREAK CODE

☐ (1) MENTAL ☐ (2) CHRONIC

26 PROCEDURES *(List by date, surgical operation performed)*

25. PROCEDURE CODE

33 CERTIFICATION OF SPECIAL CIRCUMSTANCES BY ATTENDING PHYSICIAN OR DENTIST

I certify that *(Complete appropriate space(s))*

a ☐ Services were necessary for treatment of a bonafide medical emergency.

b. _____ Days PRIVATE ROOM care billed on this claim were required for proper care and treatment of the patient.

c. _____ Days / hours PRIVATE DUTY NURSING CARE billed on this claim were required for proper care and treatment of the patient.

d. ☐ Other (Specify)

DATE AND SIGNATURE OF ATTENDING PHYSICIAN OR DENTIST *(Only when an entry made in this Item 33)*

34 CERTIFICATION OF SOURCE OF CARE

I certify that

(1) This statement is for services furnished the patient as authorized by the attending physician or dentist.

(2) The amounts claimed in Item 28 are true and correct and do not exceed those charged the general public for like services

(3) Except for the amount shown in Item 30 payment for these services has not been received.

(4) Except for the amount shown in Item 30 no claim for payment for services included in the statement and authorized under the Civilian Health and Medical Program of the Uniformed Services will be made upon the patient or sponsor.

DATE AND SIGNATURE OF CLAIMANT OR AUTHORIZED REPRESENTATIVE OF HOSPITAL

27 RELATED AUTHORIZED ADMISSIONS

DATE ADMITTED TO HOSPITAL	DATE DISCHARGED FROM HOSPITAL	DEDUCTIONS APPLIED
		$

28 AUTHORIZED SERVICES

TYPE	DAYS	RATE	CHARGES
a. ROOM PRIVATE			
b. *(Avg-Semi-Private Rate)*			
c. ROOM, S-PRIVATE *(2, 3, 4 Beds)*			
d. ROOM WARD			
e. ROOM NURSERY			
f. OPERATING ROOM			
g. DELIVERY ROOM			
h. ANESTHESIA SERVICES *(By hospital employee)*			
i. LABORATORY SERVICES			
j. X-RAY SERVICES			
k. DRESSING AND CAST SERVICES			
l. DRUGS AND MEDICATION SERVICES			
m. OTHER SERVICES *(Specify)*			
29 TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED			
30. (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*			
31 DUE FROM GOVERNMENT			
32. VARIANCE (ITEM 29 LESS 30 AND 31)			

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws.

FORM DA 1 JUN 67 1863-2 (Civilian Hospitals) REPLACES DA FORM 1863-1, 1 SEP 61 WHICH IS OBSOLETE

Form Approved Comptroller General, U. S., 22 Sep 67

EXHIBIT 2-B

SPECIAL INSTRUCTIONS
(Please check form for completeness to eliminate delay in processing)

The sponsor, patient or responsible family member will be required to complete Items 1 through 13 of this claim form, and the Source of Care will complete the remainder of the form. The completed claim will then be forwarded to the appropriate fiscal administrator for processing.

SECTION I
INSTRUCTIONS FOR COMPLETION OF ITEMS BY PATIENT

ITEM 5. IDENTIFICATION CARD. If the DD Form 1173 is used, the Effective Date is located on the reverse side of the card in block 15b. The Expiration Date is located on the front side of the card in block 3.

If DD Form 2(Ret) or PHS Form 1866-3(Ret) is used, the Effective Date is located on the reverse side of the card in block entitled DATE OF ISSUE. The Expiration Date is located on the front of the card in the block eatitled EXPIRATION DATE.

ITEM 6. BASIS FOR CARE-ACTIVE DUTY DEPENDENTS ONLY

OUTPATIENT CARE - Spouses and children of active duty personnel may elect to obtain OUTPATIENT care from either civilian or uniformed services facilities. (Prenatal and postnatal care are considered part of maternity care.)

INPATIENT CARE - Spouses and children of active duty personnel who reside APART from their sponsor may obtain INPATIENT care from either civilian or uniformed services facilities.

Spouses and children of active duty personnel who reside WITH their sponsor must obtain INPATIENT care including MATERNITY care from uniformed services medical facilities unless the care is provided under emergency conditions or on a trip. If these exceptions do not apply, care from civilian sources at Government expense may be obtained within the United States & Puerto Rico ONLY if a Nonavailability Statement (DD Form 1251), indicating that the required care is not available from a uniformed services medical facility located within a reasonable distance of the patient's residence, is attached to this claim.

DEPENDENT PARENTS AND PARENTS-IN-LAW are NOT authorized civilian medical care at Government expense under any circumstances.

ITEM 8. SERVICE NUMBER OR SOCIAL SECURITY NUMBER. The sponsor's service number or social security number is located in block 12 of the dependent's DD Form 1173.

ITEM 10. ORGANIZATION AND DUTY STATION. Active duty dependents enter the present duty assignment of sponsor. Retired and dependents of retired enter residence of Retiree. Dependents of deceased leave blank.

ITEM 13. CERTIFICATION

If an authorization in addition to that contained in the executed certificate in Item 13 is considered necessary for the release of medical records pertinent to the care furnished, then the source of civilian medical care should obtain the same.

The Law (10 U.S.C. 1086(d)) provides that no benefits under this program may be provided to a retired person or the dependent of a retired or deceased member enrolled in any other insurance, medical service or health plan provided by law or through employment unless that person certifies that the particular benefit he is claiming is not payable under the other plan.

The certificate will be signed by the retiree, dependent receiving care when 18 years of age or over, sponsor or other responsible family member

SECTION II
INSTRUCTIONS FOR COMPLETION OF ITEMS
BY SOURCE OF CARE

ITEM 15. Contractor use only.

ITEM 16. STATEMENT. Check applicable block to reflect appropriate type of statement being submitted.

ITEM 22. DIAGNOSIS. Use standard nomenclature. Also, check applicable block if diagnosis is mental or chronic.

ITEMS 23, 24 and 25. Contractor use only.

ITEM 26. PROCEDURES. Enter all surgical operations performed.

ITEM 27. RELATED AUTHORIZED ADMISSIONS. Enter admission and discharge dates for all periods of hospitalization during period of care (Item 19) covered by this statement.

ITEM 28. AUTHORIZED SERVICES. Enter only information relative to type of service or services authorized under the Civilian Health and Medical Program of the Uniformed Services for which this statement is being submitted.

ITEM 29. TOTAL CHARGES. Enter total of the authorized services furnished, as shown in Item 28.

ITEM 30. PAID BY OR DUE FROM PATIENT (Enter patient's liability.)

a. Dependents of active duty personnel.

(1) INPATIENT CARE – The first $25.00 of the hospital charges or $1.75 per day, whichever amount is greater. No charge for services of professional personnel.

(2) OUTPATIENT CARE – For authorized outpatient care claimed during a fiscal year (1 July through 30 June) for only one family member, the patient (or sponsor) must pay the first $50.00 of the charges. If benefits are claimed for two or more members of a family group, the patient (or sponsor) must pay the first $100 of the charges. After the deductible has been met, the patient will pay 20% of all charges incurred for authorized outpatient care for the remainder of the fiscal year.

b. Retired personnel and their dependents and dependents of deceased personnel.

(1) INPATIENT CARE – 25% of hospital charges and fees of professional personnel.

(2) OUTPATIENT CARE – The patient or family group will be required to pay the same deductible as is applicable to dependents of active duty personnel. Thereafter, the patient or family group will be required to pay 25% of any expenses incurred for authorized outpatient care for the remainder of the fiscal year.

ITEM 31. DUE FROM GOVERNMENT. Hospitals will enter the amount due from the Government taking into consideration the rate agreements with contractors when such agreements exist.

ITEM 32. VARIANCE. MUST be completed for those hospitals which have rate agreements with contractors.

ITEM 33. CERTIFICATION OF SPECIAL CIRCUMSTANCES.

Enter figures required, or check blocks as appropriate for the patient being treated. To be payable, claims covering authorized care furnished to a hospitalized inpatient in a medical facility which does not meet the definition of "Hospital" under the Program must show that treatment was a bonafide medical emergency by checking the block, Emergency. The block, Other, Specify, will be utilized, with a short specific statement included, when an additional certification not listed is required. The attending physician or dentist must sign the certificate prior to submission of the claim for payment.

ITEM 34. CERTIFICATION OF SOURCE OF CARE

This certificate must be signed prior to submission of claim for payment.

EXHIBIT 3-A

SERVICES AND/OR SUPPLIES PROVIDED BY CIVILIAN SOURCES (EXCEPT HOSPITALS)

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS)

SEE INSTRUCTIONS ON REVERSE

SECTION I *(To be completed by patient or other responsible family member. Please print or type)*

PATIENT DATA

1. NAME *(last, first, middle initial)*
2. DATE OF BIRTH
3. ADDRESS *(Include Zip Code)*
4. PATIENT IS A *(Check one)*
   ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE
5. IDENTIFICATION CARD *(DD Form 1173, DD Form 2 or PHS Form 1866-3)*
   CARD NO.
   EFFECTIVE DATE — MONTH / DAY / YEAR
   EXPIRATION DATE — MONTH / DAY / YEAR
6. BASIS FOR CARE - ACTIVE DUTY DEPENDENTS ONLY *(Check one)*
   ☐ (1) RESIDING APART FROM SPONSOR ☐ (2) RESIDING WITH SPONSOR OO FORM 1251 ATTACHED ☐ (3) OUTPATIENT
   ☐ (4) OTHER *(Specify)*

SERVICE MEMBER DATA

7. NAME OF SPONSOR *(last, first, middle initial)*
8a. SERVICE NUMBER
8b. SOCIAL SECURITY ACCOUNT NUMBER
9. GRADE
10. ORGANIZATION AND DUTY STATION *(Home Port for Ships) (Address for Retired)*
11. SPONSOR'S OR RETIREE'S BRANCH OF SERVICE
    ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN
    ☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA
12. STATUS
    ☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

13. CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.

If a RETIRED MEMBER or dependent of a retired or deceased member, I certify that to the best of my knowledge and belief, that *(Check appropriate box) (Delete portion in parenthesis not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service, or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service, or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan.

Name (print or type) _____ (Relationship to Patient) _____ Date _____ Signature _____

SECTION II *(To be completed by Source of Care)*

14. NAME AND ADDRESS OF SOURCE OF CARE *(Include Zip Code)*
a. SOURCE OF CARE LOCATION CODE
b. PROVIDER OF SERVICES
   ☐ (1) ATTENDING PHYSICIAN
   ☐ (2) OTHER *(Specify)*
c. PATIENT STATUS
   ☐ (1) INPATIENT
   ☐ (2) OUTPATIENT
15. NAME AND TITLE OF INDIVIDUAL ORDERING CARE
16. INCLUSIVE DATES OF CARE
    FROM — MONTH / DAY / YEAR — TO — MONTH / DAY / YEAR
17. DIAGNOSIS *(Use standard nomenclature)*
    (Check when applicable) ☐ *services were necessary for treatment of a bonafide medical emergency*
a. INTL. STAT. CODE
b. 12 - BREAK CODE
18. RELATED HOSPITALIZATION *(If applicable)*
    FROM — TO
19. ENTER ESTIMATED OR ACTUAL DATE OF DELIVERY IN MATERNITY CASES. LIST BY DATE SURGICAL OPERATIONS AND/OR CARE FURNISHED INCLUDING VISITS FOR WHICH SEPARATE CHARGES ARE CLAIMED *(Type or print)* *(Attach additional sheets if required)*

DATE(S) OF SERVICE	a. ITEM OR DESCRIPTION OF SERVICE	b. CHARGES	c. PROCEDURE CODE
		$	
d. TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED		$	
e. (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*		$	
f. DUE FROM GOVERNMENT TO SOURCE OF CARE		$	
g. DUE PATIENT OR SPONSOR, REIMBURSEMENT		$	

20. CERTIFICATION BY SOURCE OF CARE

I certify that the services and / or supplies listed hereon were performed or authorized by the attending physician, dentist or other professional personnel in charge, that payment due from the Government has not been received, and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and / or supplies listed hereon.

I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) _____ Title _____ Date _____ Signature _____

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws.

DA FORM 1 JUN 67 1863 – 2 (Civilian Sources) REPLACES DA FORM 1863 - 2, 1 SEP 61, WHICH IS OBSOLETE. Form Approved Comptroller General, U. S., 22 Sep 67

EXHIBIT 3-B

SPECIAL INSTRUCTIONS
(please check form for completeness to eliminate delay in processing)

This form will be used by all civilian sources of care other than hospitals, pharmaceutical services in the United States and Puerto Rico, and sources providing care under the Handicapped Program.

The sponsor, patient or responsible family member will be required to complete Items 1 through 13 of this claim form, and the source of care will complete the remainder of the form. The completed claim will then be forwarded to the appropriate fiscal administrator for processing

SECTION I
INSTRUCTIONS FOR COMPLETION OF ITEMS BY PATIENT

ITEM 5. IDENTIFICATION CARD. If the DD Form 1173 is used, the Effective Date is located on the reverse side of the card in block 15b The Expiration Date is located on the front sida of the card in block 3.

If DD Form 2(Ret) or PHS Form 1866—3(Ret) is used, the Effective Date is located on the reverse side of the card in block entitled DATE OF ISSUE. The Expiration Date is located on the front of the card in the block entitled EXPIRATION DATE.

ITEM 6. BASIS FOR CARE-ACTIVE DUTY DEPENDENTS ONLY

OUTPATIENT CARE-Spouses and children of active duty personnel may elect to obtain OUTPATIENT care from either civilian or uniformed services facilities. (Prenatal and postnatal care are considered part of maternity care.)

INPATIENT CARE-Spouses and children of active duty personnel who reside APART from their sponsor may obtain INPATIENT care from either civilian or uniformed services facilities.

Spouses and children of active duty personnel who reside WITH their sponsor must obtain INPATIENT care including MATERNITY care from uniformed services medical facilities unless the care is provided under emergency conditions or on a trip. If these exceptions do not apply, care from civilian sources at Government expense may be obtained within the United States & Puerto Rico ONLY if a Nonavailability Statement (DD Form 1251), indicating that the required care is not available from a uniformed services medical facility located within a reasonable distance of the patient's residence, is attached to this claim.

DEPENDENT PARENTS AND PARENTS-IN-LAW are NOT authorized civilian medical care at Government expense under any circumstances.

ITEM 8a. SERVICE NUMBER. b. SOCIAL SECURITY ACCOUNT NUMBER. Enter the sponsor's service number *(located in block 12 of the dependent's DD Form 1173)*, and sponsor's social security account number.

ITEM 10. ORGANIZATION AND DUTY STATION. Active duty dependents enter the present assignment of sponsor. Retired and dependents of retired enter residence of Retiree. Dependents of deceased leave blank.

ITEM 13. CERTIFICATION

If an authorization in addition to that contained in the executed certificate in Item 13 is considered necessary for the release of medical records pertinent to the care furnished, then the source of civilian medical care should obtain the same.

The Law (10 U.S.C. 1088(d)) provides that no benefits under this program may be provided to a retired person or the dependent of a retired or deceased member enrolled in any other insurance, medical service or health plan provided by law or through employment unless that person certifies that the particular benefit be is claiming is not payable under the other plan.

The certificate will be signed by the retiree, dependent receiving care when 18 years of age or over, sponsor or other responsible family member.

SECTION II
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SOURCE OF CARE
(Shaded areas are for CONTRACTOR USE ONLY)

ITEM 15. NAME & TITLE OF INDIVIDUAL ORDERING CARE. Individual ordering care must be the attending physician, dentist or other professional person in charge.

ITEM 17. DIAGNOSIS. EMERGENCY- This block will be checked only when a bonafide medical emergency exists.

ITEM 18. RELATED HOSPITALIZATION. Enter the inclusive dates of related hospitalization if applicable.

ITEM 19a, b and c. Enter only those services and/or supplies which are authorized for payment under CHAMPUS All services and supplies should be itemized to insure prompt and proper payment. Payment by the Government to the source of services and supplies is based normally upon usual, customary, and reasonable charges. However, should a physician, dentist, or other professional person expend unusual effort for proper care of the patient, be should submit a clinical summary with his claim in support of a request for special consideration of the amount payable for his services.

d. Enter total of the authorized charges in Column 19h.

e. Enter the patient's liability.

(1) Dependents of active duty personnel.

(a) Outpatient Care. For authorized outpatient care claimed during a fiscal year (1 July through 30 June) for only one family member, the patient (or sponsor) shall be required to pay the first $50.00 of the charges. If benefits are claimed for two or more members of a family group, the patient (or sponsor) must pay the first $100.00 of the charges. After the deductible has been met, the patient (or sponsor) will pay 20% of all charges incurred for authorized outpatient care for the remainder of the fiscal year. The Government's share of the cost of benefits after the deductible has been met will be 80%.

(b) Inpatient Care. No charge for professional services.

(2) Retired personnel and their dependents and the dependents of deceased personnel.

(a) Outpatient Care. The patient or family group will be required to pay the same deductible as is applicable to dependents of active duty personnel. Thereafter the patient or family group will be required to pay 25% of any expenses incurred for authorized outpatient care for the remainder of the fiscal year. The Government's share of the cost of benefits provided after the deductible has been met will be 75%.

(b) Inpatient Care. The patient (or sponsor) shall be required to pay 25% of the fees of professional personnel for authorized inpatient care. The Government's share of the cost will be 75% of the total charge for authorized inpatient care.

ITEM 20. CERTIFICATION BY SOURCE OF CARE. The Program operates under the full payment concept which means that, except for the amount payable by the patient, the amount paid by the Government to the source of services and/or supplies shall constitute payment in full for the authorized care, and no further amount will then be due from any source for those same services or supplies. Therefore, it is necessary that the certification in Item 20 be completed without alteration. In the event this is not done, payment from public funds to the source of care will not be made.

EXHIBIT 4-A

SEE INSTRUCTIONS ON REVERSE	**SERVICES AND/OR SUPPLIES - HANDICAPPED PROGRAM (ACTIVE DUTY DEPENDENTS ONLY)** CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES (CHAMPUS) For use of this form, see AR 40-121; the proponent agency is Office of The Surgeon General.	CASE NUMBER

SECTION I *(To be completed by patient or other responsible family member. Please print or type)*

PATIENT DATA		SERVICE MEMBER DATA		
1 NAME *(last, first, middle initial)*	2 DATE OF BIRTH	6 NAME OF SPONSOR *(last, first, middle initial)*		
3 ADDRESS *(Include Zip Code)*		7a SERVICE NUMBER	7b SOCIAL SECURITY ACCOUNT NUMBER	8 PAY GRADE
		9 ORGANIZATION AND DUTY STATION *(Home Port for Ships)*		
4 PATIENT IS A *(Check one)* ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON				
5 IDENTIFICATION CARD *(DD Form 1173)* CARD NO EFFECTIVE DATE EXPIRATION DATE	MONTH DAY YEAR	10 SPONSOR'S BRANCH OF SERVICE ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN ☐ (5) USCG ☐ (6) USPHS ☐ (7) ESSA		

11 CERTIFICATION

I certify to the best of my knowledge and belief the above information in Section I is correct. The handicapped case has been accepted by OCHAMPUS or appropriate overseas commander. To the extent that I have authority to do so I hereby authorize the release of medical records in this case to both the contractor and the Government.

Name (print or type) | Relationship to Patient | Date | Signature

SECTION II *(To be completed by Source of Care)*

12 NAME AND ADDRESS OF SOURCE OF CARE *(Include Zip Code*	a SOURCE OF CARE LOCATION CODE	b TYPE OF FACILITY
	c TYPE OF CARE ☐ (1) HOSPITAL ☐ (2) INSTITUTION ☐ (3) OUTPATIENT	☐ (1) PUBLIC OR STATE ☐ (2) PRIVATE NON PROFIT ☐ (3) PRIVATE PROFIT

13 NAME AND TITLE OF INDIVIDUAL ORDERING CARE

14 DIAGNOSIS *(Use standard nomenclature)*	a 12 BREAK CODE
	b INTL STAT CODE
	c INCLUSIVE DATE OF CARE FROM TO

15 DATES OF SERVICE	a ITEM OR DESCRIPTION OF SERVICE	b CHARGES		c PROCEDURE CODE
		$		
d TOTAL CHARGES THIS STATEMENT FOR CARE AUTHORIZED		$		
e (PAID BY) OR (DUE FROM) PATIENT *(Cross out one)*		$		
f DUE FROM GOVERNMENT TO SOURCE OF CARE		$		
g DUE PATIENT OR SPONSOR, REIMBURSEMENT		$		

16 CERTIFICATION BY SOURCE OF CARE

I certify that the services and/or supplies listed hereon were performed or authorized by the attending physican, dentist or other professional personnel in charge, that payment due from the Government has not been received, and that, except for the amount payable by the patient in accordance with the terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and /or supplies listed hereon.

I further certify that I am not an intern, resident or otherwise in training status for which I am receiving compensation for services listed on this claim.

Name (print or type) | Title | Date | Signature

The persons signing this form are advised that the willful making of a false or fraudulent statement herein renders them liable to prosecution under applicable Federal Laws.

17. FISCAL ADMINISTRATOR USE ONLY

DA FORM 1 JUN 67 1863-3 (Handicapped)

Form Approved
Comptroller General, U.S., 22 Sep 67

EXHIBIT 4-B

SPECIAL INSTRUCTIONS

(Please check form for completeness to eliminate delay in processing)

This form is for submission of claims by all sources of service and or supplies, which pertain ONLY to the Handicapped portion of the Civilian Health and Medical Program of the Uniformed Services.

No benefits are payable under the Handicapped Program unless the Executive Director, OCHAMPUS, or appropriate oversea commander has accepted the dependent for benefits under the program and approved a plan for management of the handicapping condition. At the time of acceptance of the dependent in the program and approval of benefits, a case number is assigned and claim forms provided the sponsor or other responsible family member who must complete Items 1 through 11. The source of care will complete the remainder of the form. The completed claim form will then be forwarded to the appropriate fiscal administrator for processing.

SECTION I
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SPONSOR OR OTHER RESPONSIBLE FAMILY MEMBER

ITEM 5. IDENTIFICATION CARD. The EFFECTIVE DATE is located on the reverse side of DD Form 1173 in block 15b. The EXPIRATION DATE is located on the front side of DD Form 1173 in block 3.

ITEM 7a SERVICE NUMBER 7b SOCIAL SECURITY ACCOUNT NUMBER Enter sponsor's service number (located in block 12 of Dependent's DD Form 1173) in 7a and sponsor's social security account number in 7b

ITEM 8. PAY GRADE Enter appropriate pay grade, E-1, W-1, O-1, etc. (See chart below)

ITEM 9. ORGANIZATION AND DUTY STATION Enter the present duty assignment of sponsor.

ITEM 11. CERTIFICATION

This certificate MUST be signed prior to submission of the claim for payment. It will be signed by the dependent receiving care when 18 years of age or over, by the sponsor, or other responsible family member. If an authorization, in addition to that contained in the executed certificate in Item 11, is considered necessary for the release of medical records pertinent to the care furnished to the dependent, then the source of civilian medical care should obtain the same.

SECTION II
INSTRUCTIONS FOR COMPLETION OF ITEMS BY SOURCE OF CARE

ITEM 12c. TYPE OF CARE Hospital—for any service or supply provided while in an inpatient status (patient entered on the roll of the hospital as an inpatient.)

Institution—care provided in private nonprofit, public or state institutions and facilities. Normally, this is residential care.

Outpatient—services provided on a visit basis in the home, hospital, clinic, institution, agency or office by professional persons.

ITEM 13. NAME & TITLE OF INDIVIDUAL ORDERING CARE Individual ordering care must be the attending physician, dentist, or other professional person in charge.

ITEM 14 DIAGNOSIS. Only moderately or severely mentally retarded and seriously physically handicapped spouses and children of ACTIVE DUTY members may receive care under the handicapped portion of the CHAMPUS. Therefore, the diagnosis of these patients must reflect the degree of impairment. Further, original diagnosis of such conditions must be made by a physician.

c. Inclusive dates of care covered by this claim.

ITEM 15 a, b, and c. Enter only those services and or supplies which are authorized for payment under the CHAMPUS All services and/or supplies should be itemized to insure prompt and proper payment.

d. Enter total of the authorized charges in column 15b.

e. Enter the patient's (Sponsor's) liability, which is limited to

If the cost of services provided his dependent under the Handicapped Program in a particular month is less than the amount prescribed for his pay grade, (see chart) the entire cost must he paid by the service member. When the cost per month exceeds the amount shown for his pay grade, he shall be required to pay the amount shown for his pay grade plus the amount, if any, by which the total charge exceeds his payment and the Government's maximum payment of $350.00.

f. The Government's share of the cost of benefits provided a particular dependent under the handicapped program shall not exceed $350.00 per month except in cases of multiple dependents incurring expenses.

ITEM 16. CERTIFICATION BY SOURCE OF CARE. This certificate must be signed prior to submission of claim for payment.

AMOUNT	PAY GRADE	ARMY	MARINE CORPS	COAST GUARD/NAVY	AIR FORCE
$ 45	E–9	Sergeant major	Sergeant major Master gunnery sergeant	Master chief petty officer	Chief master sergeant
40	E–8	First sergeant Master sergeant	First sergeant Master sergeant	Senior chief petty officer	Senior master sergeant
35	E–7	Platoon sergeant Sergeant first class Master sergeant [1] Specialist Seven	Acting master sergeant [2] Gunnery sergeant	Chief petty officer	Master sergeant
30	E–6	Staff sergeant Sergeant first class [1] Specialist Six	Acting gunnery sergeant [2] Staff sergeant	Petty officer first class	Technical sergeant
25	E–5	Sergeant Specialist Five	Acting staff sergeant [2] Sergeant	Petty officer second class	Staff sergeant
25	E–4	Corporal Specialist Four	Acting sergeant [2] Corporal	Petty officer third class	Airman first class
25	E–3	Private first class	Acting corporal [2] Lance corporal	Seaman	Airman second class
25	E–2	Private	Private first class	Seaman apprentice	Airman third class
25	E–1	Private	Private	Seaman recruit	Airman, basic

[1] Transitional title for those who held this grade continuously since 31 May 1958

[2] Transitional title for those holding pay grade 31 December 1958.

AMOUNT	PAY GRADE	ARMY, AIR FORCE, and MARINE CORPS	COAST GUARD, NAVY and ESSA
$250	O–10	General	Admiral
200	O–9	Lieutenant general	Vice admiral
150	O–8	Major general	Rear admiral (upper half)
100	O–7	Brigadier general	Rear admiral (lower half)
75	O–6	Colonel	Captain
65	O–5	Lieutenant colonel	Commander
50	O–4	Major	Lieutenant commander
45	O–3	Captain	Lieutenant
40	O–2	First lieutenant	Lieutenant (junior grade)
35	O–1	Second lieutenant	Ensign

AMOUNT	PAY GRADE	WARRANT OFFICERS
$50	W–4	Chief warrant officer, W–4
50	W–3	Chief warrant officer, W–3
45	W–2	Chief warrant officer, W–2
45	W–1	Warrant officer, W–1

NOTE: Because of the numerous grade titles of the personnel in the commissioned corps of the Public Health Service, they have not been listed on this form.

EXHIBIT 5

PRESCRIPTION BILLING – OUTPATIENT PHARMACEUTICAL SERVICES – CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES | *SEE INSTRUCTIONS ON FRONT FLAP*

SECTION I – PATIENT AND SPONSOR DATA

1. PATIENT'S NAME AND ADDRESS *(Include Zip Code)*

2. DATE OF BIRTH

3. PATIENT IS ☐ (1) SPOUSE ☐ (2) DAUGHTER ☐ (3) SON ☐ (4) RETIREE

4. IDENTIFICATION CARD *(DD Form 1173, DD Form 2, or PHS Form 1866–3)*

CARD NUMBER

	MONTH	DAY	YEAR
EFFECTIVE DATE			
EXPIRATION DATE			

5. SPONSOR'S NAME *(Last, First, Middle Initial)*

6a. SERVICE NUMBER

6b. SOCIAL SECURITY ACCOUNT NUMBER

7. STATUS ☐ (1) ACTIVE DUTY ☐ (2) RETIRED ☐ (3) DECEASED

8. BRANCH OF SERVICE ☐ (1) USA ☐ (2) USAF ☐ (3) USMC ☐ (4) USN ☐ (5) USCG ☐ (6) USPHS ☐ (7) USESSA

9. CERTIFICATION OF PATIENT OR SPONSOR. I certify that the above information is correct; that I have received the material and service described hereon and I authorize the release of any information pertaining to this service to both the Contractor and the Government. If a RETIRED MEMBER, or a dependent of a retired or deceased member, I certify that to the best of my knowledge and belief that *(Check applicable box and delete portion in parenthesis that is not applicable)*

☐ (I am not) (the patient is not) enrolled (neither is sponsor) in any other insurance, medical service or health plan provided by law or through employment.

☐ (I am) (the patient is) enrolled (so is sponsor) in another insurance, medical service or health plan provided by law or through employment; however the particular benefits claimed on this form are not payable under the other plan.

NAME *(Print or Type)* | DATE | RELATIONSHIP TO PATIENT | SIGNATURE

SECTION II – VENDOR PHARMACY DATA

10. PRESCRIPTION NUMBER	10. PRESCRIPTION DATE FILLED	11. MEDICATION NAME, STRENGTH, DOSAGE FORM	12. QUANTITY	13. NEW OR REFILL	14. ACQUISITION COST	15. PROFESSIONAL FEE	16. TOTAL *(Items 14 plus 15)*	17. (PAID BY) OR (DUE FROM) PATIENT	18. DUE FROM GOVERNMENT	FOR USE BY FISCAL ADMINISTRATOR		

19. OUTPATIENT DEDUCTIBLE CERTIFICATE *(Enter State and Expiration Date)*

20. PHARMACY CODE

21. NAME AND ADDRESS OF PHARMACY *(Include Zip Code)*

22. CERTIFICATION OF PHARMACIST. I certify that I have furnished the medication and services described hereon and that the information is correct to the best of my knowledge. Except for the amount payable by the patient in accordance with terms of the Civilian Health and Medical Program of the Uniformed Services, the amount paid by the Government will be accepted as payment in full for the authorized services and/or supplies listed hereon.

SIGNATURE OF PHARMACIST AND DATE

DA FORM 1863-4, 1 Jun 69

☆ U. S. GOVERNMENT PRINTING OFFICE: 1969 — 358-296

correct and the co-insurance declaration statement. This last statement is especially important if the beneficiary is a retired member or his dependent.

Upon completion of treatment the remainder of the form is filled out by the provider and submitted to one of the fiscal administrators or hospital contractors listed on Exhibit 6. In many cases, either because of the policies of the provider or the desires of the sponsor/patient, the patient will pay the provider for the full cost of the treatment and then submit a claim for reimbursement. The actual recipient of the claim depends on the geographic area where the treatment was provided. For example, in California all inpatient claims are submitted to either Blue Cross of Northern California or Blue Cross of Southern California. All claims in the state from physicians and other non-hospital type providers are submitted to Blue Shield of California. Dental claims for California and all other states are sent to the Colorado Dental Service, Denver, Colorado, while claims from Christian Scientist practitioners are submitted to Massachusetts Blue Cross, Boston, Massachusetts.

The claims processing procedures used by the various fiscal administrators and hospital contractors are fully described in the CHAMPUS Program Manual issued by OCHAMPUS. Since the inputs and required outputs are standardized, it will be assumed that each of these agencies follows a somewhat similar claims processing procedure. The systems described in the

EXHIBIT 6

CHAMPUS FISCAL ADMINISTRATORS
AND HOSPITAL CONTRACTORS

Alabama - Mutual of Omaha (BC)
Alaska - Blue Cross, Washington-Alaska, Inc. (BC)
Arizona - Blue Shield Medical Services (BC)
Arkansas - Blue Cross-Blue Shield, Inc. (M)
California - Blue Shield of California (BC)
Canada - Mutual of Omaha (M)
Colorado - Medical Service Inc. (BC)
Connecticut - Connecticut General Life Insurance Co. (BC)
Delaware - Blue Cross and Blue Shield of Delaware, Inc. (BC)
District of Columbia - Medical Service of District of Columbia (includes all of Washington, D. C., and contiguous counties and cities of Maryland and Virginia) (BC)
Florida - Blue Shield of Florda, Inc. (M)
Georgia - Medical Association of Georgia (M)
Hawaii - Medical Service Association (BC)
Idaho - North Idaho District Medical Service (BC)
Illinois - Mutual of Omaha (M)
Indiana - Indiana State Medical Association (M)
Iowa - Iowa Medical Service (M)
Kansas - Kansas Blue Shield (M)
Kentucky - Physician's Mutual Inc. (BC)
Louisiana - Continental Life and Health Ins. Co. (M)
Maine - Associated Hospital Service of Maine (BC)
Maryland - Maryland Blue Shield (except areas near Washington, D.C.) (BC)
Massachusetts - Blue Shield Inc. and Massachusetts Blue Cross (BC)
Mexico - Mutual of Omaha (M)
Michigan - Michigan Medical Service (BC)
Minnesota - Minnesota Medical Service, Inc. (M)
Mississippi - Mississippi State Medical Association (BC)
Missouri - Missouri Medical Service (M)
Montana - Montana Physicians Service (BC)
Nebraska - Nebraska Medical Service (M)
Nevada - Nevada State Medical Association (BC)
New Hampshire - Vermont Physician Service (BC)
New Jersey - Medical-Surgical Plan of New Jersey (BC)
New Mexico - Surgical Service Inc., of New Mexico (BC)
New York - United Medical Service, Inc. (BC)
North Carolina - North Carolina Blue Cross and Blue Shield, Inc. (BC)
North Dakota - Blue Shield of North Dakota (M)
Ohio - Mutual of Omaha (M)
Oklahoma - Oklahoma Physicians Service (M)
Oregon - Oregon Physicians Service (BC)

EXHIBIT 6 (CONTINUED)

Pennsylvania - Medical Service Association of Pennsylvania (BC)
Puerto Rico - Mutual of Omaha (BC)
Rhode Island - Mutual of Omaha (BC)
South Carolina - Mutual of Omaha (M)
South Dakota - South Dakota Medical Service, Inc. (M)
Tennessee - Blue Cross and Blue Shield of Tennessee (BC)
Texas - Mutual of Omaha (M)
Utah - Blue Shield of Utah (BC)
Vermont - Vermont Physician Service (BC)
Virginia - Blue Shield of Virginia (except areas near Washington, D. C.) (BC)
Washington - Blue Cross of Washington-Alaska, Inc. (BC)
West Virginia - Medical Surgical Care, Inc. (BC)
Wisconsin - Wisconsin Physicians Service (M)
Wyoming - Wyoming Medical Service, Inc. (BC)

All Dental Claims - Colorado Dental Service
All Christian Scientist Claims - Massachusetts Blue Shield, Inc.

NOTE: Hospital contractors are indicated in the above list by letters in parenthesis: (M) denotes Mutual of Omaha and (BC) denotes Blue Cross Association.

following sections can thus be considered as a representative example of the claims processing systems utilized by the CHAMPUS contractors.

A. BLUE CROSS ASSOCIATION

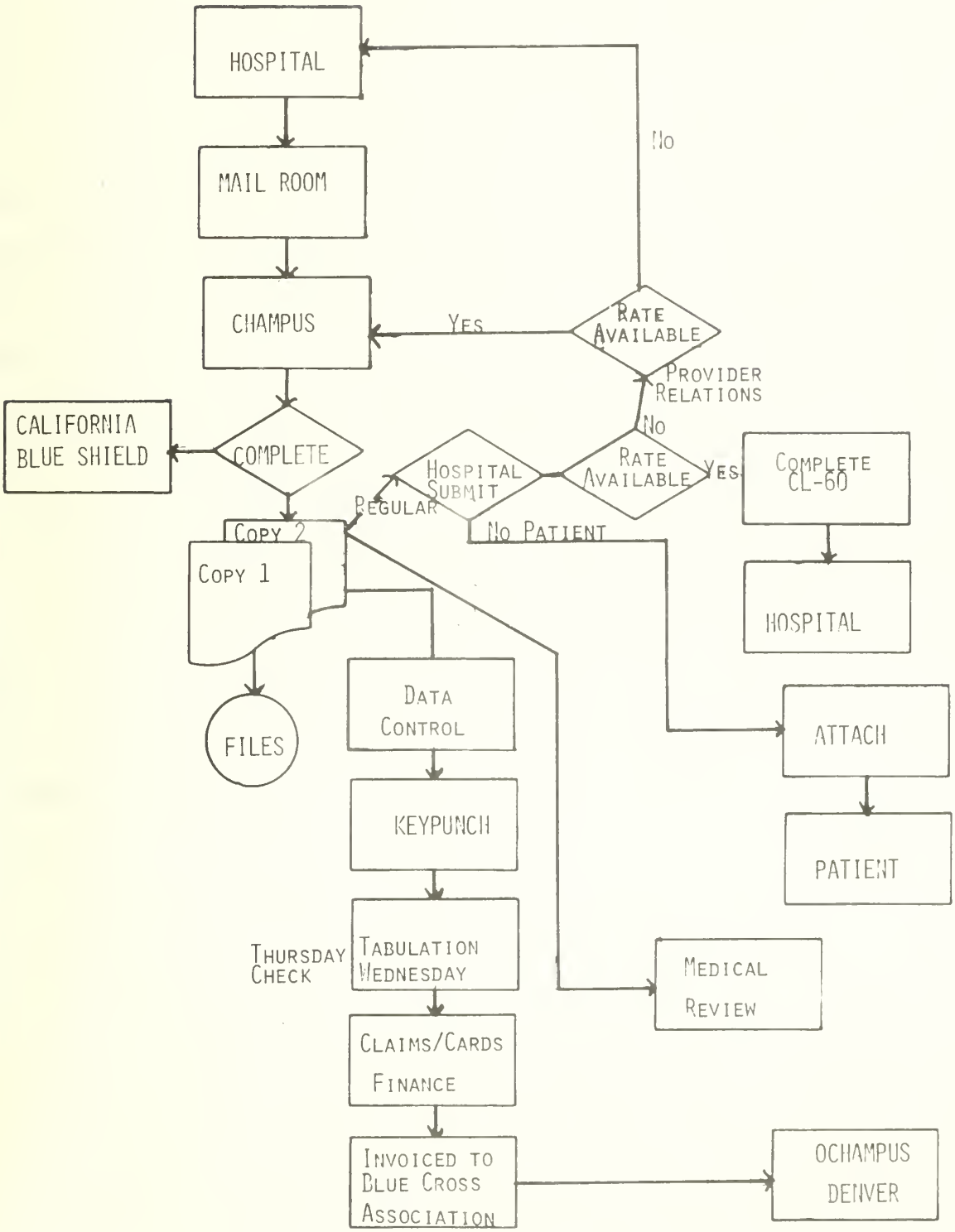
As noted in Exhibit 6, the Blue Cross Association is the primary hospital contractor for inpatient care in thirty-three geographic locations. Each geographic location's Blue Cross organization acts as a subcontractor to process CHAMPUS claims. Blue Cross of Northern California, located in Oakland, California, is typical of these subcontractors. Its area of responsibility is all of Northern California, that is, all of California North of an imaginary line drawn across the state just to the North of Los Angeles County [Ref. 4].

Blue Cross receives approximately 905 inpatient claims per week. The average turnaround time for CHAMPUS claims, from the time the claim is received until the payment check goes into the mail, is seven to eight days. Exhibit 7 depicts the general flow of the claims processing system used by Blue Cross of Northern California. Information concerning the rate structures and the process concerning the "CL-60" is considered confidential information and, as such, was not made available. About 25 percent of all claims cannot be processed on the first submission due to errors and incompletions. The most common errors experienced by Blue Cross are:

1. Errors in dependent identification care information.

EXHIBIT 7

CHAMPUS PROCESSING SYSTEM
CHAMPUS CLAIM, DA-1863-1



2. Physician's name illegible, missing, or is not on their list of qualified hospital staff members.

3. Item thirteen, Other Insurance, was not marked to indicate whether other forms of health insurance were owned by the patient.

4. The diagnosis, as listed, was incomplete or of a questionable nature.

5. A non-availability statement was not attached to the submitted claim.

Upon receipt, all claims are date stamped in their Mail Room. They are then given to processors and are entered into the processing system. Each processor reviews items one through thirty-four (See Exhibit 2) to make certain that the claim is complete. They also review and determine benefit and patient eligibility. If the claim is incomplete, or if it is determined that a review of the diagnosis is needed, the claim would be returned to the provider or forwarded to Medical Review. In the former instance the provider hospital completes the missing information or corrects the errors and resubmits the claim to Blue Cross. In the latter instance a member of Medical Review makes a determination of the diagnosis as being eligible or not eligible as a benefit of the CHAMPUS Program. The claim is then either returned to the provider or re-entered into the processing system. It should be noted that these reviews are for patient and benefit eligibility only. If it is determined that a diagnosis is

not properly a benefit, the liability for payment of the claim falls back upon the patient. This particular feature of the CHAMPUS Program is true if the determination is made as either part of the processor review, a Medical Review, or an OCHAMPUS review.

The second review, accomplished by other than the person doing the first review, is for quality control. In this review, every item on the form is looked at for correctness. If an error is found, the claim is returned to the first processor for action in obtaining the correct information. If no errors are found, the claims are separated, i.e., originals from carbons. The processor then reviews the carbon copies to make certain all entries are correct and readable.

The third and final review is a recheck of the entire claim by a third person for completeness and correctness. Once this review is accomplished, an adding machine tape is prepared for the originals and the carbons. The tapes are compared, and if they are in agreement, the carbon copies and their adding machine tapes are sent to Data Control for keying into the computer system for further processing procedures. Details concerning the computer processing system used by Blue Cross were not made available for this study.

It was learned, however, that if there is a problem concerning charges, the problem would be resolved by persons in the Blue Cross CHAMPUS Department, their Provider Relations Department, and the provider's representatives prior to the

payment of the claim. Upon completion of processing procedures, a batch invoice is sent to the Blue Cross Association in Chicago, Illinois. This invoice, which is sent by telegraphic wire, is prepared on a weekly basis. Each invoice states the amount of claims that Blue Cross of Northern California expects to process in that week. The Blue Cross Association responds by sending Blue Cross of Northern California, and all other Blue Cross Associations, a check for the invoiced amount plus or minus a figure which represents adjustments based on the past week's actual claims processing actions. The Blue Cross Association then invoices a composite amount for all their subcontractors claims processing actions to OCHAMPUS for reimbursement. The OCHAMPUS reimbursement process will be discussed in the following chapter.

B. MUTUAL OF OMAHA INSURANCE COMPANY

The other major hospital contractor is the Mutual of Omaha Insurance Company headquartered in Omaha, Nebraska [Ref. 5]. They handle CHAMPUS hospital claims for nineteen geographic areas. This company is also a fiscal administrator for non-hospital type claims, except for dental and Christian Scientist claims. They are responsible for processing the outpatient type of claim for nine geographic areas (See Exhibit 6). Unlike the Blue Cross Association, they do not use a subcontractor system but rather process all claims in one central office. This is evidenced by the fact that they receive, on a weekly average, about 4,600 CHAMPUS hospital type claims

and more than 10,000 non-hospital type claims. Claims for drugs and durable equipment make up approximately 7.5 percent of the latter figure.

Mutual of Omaha employs a fully integrated, dedicated computer system for its claims processing. Exhibit 8, a simplified flow chart, provides an idea of the claims processing procedures that are followed in utilizing this on-line computer system. The system is composed of an IBM 145 dedicated computer utilizing IBM disc packs and high speed tape drives. Auditor interface with the computer is accomplished through Bunker-Ramo cathode ray tubes and control units. As much of the processing as could be possibly delegated to computer action has been built into this system.

The on-line system permits Mutual of Omaha to process all CHAMPUS claims in 24 hours. All claims that are entered into the system on a given day go through a batch cycle that night. The issued checks are ready for processing and mailing the next morning. Claims requiring extensive audit activity, medical review, or additional information may be held in the system for up to 30 days. Automatic review points have been established in the system so that requests for additional information are followed-up in 45 days if no response has been received by that time.

Like Blue Cross of Northern California, Mutual of Omaha has found that about 25 per cent of its claims have clerical errors. Of these, about 70 percent need clarification of or

EXHIBIT 8

NARRATIVE OF CHAMPUS CLAIMS PROCESSING

Incoming mail is sorted and given to preliminary audit by date stamped in. Returns* by-pass prelim and go directly to the audit activity file.

Prelim inputs claims by date in. Claim #** is assigned at this point by the computer. Providers are added to the file at this point also.

Prelimed claims are added into audit activity file by claim # order. Returned claims are always handled first each day.

Audited claims are batch processed each night. Those claims that do not meet the batch edits are recycled the next day. Checks are generated on payments. EOB's are prepared and return letters are written.

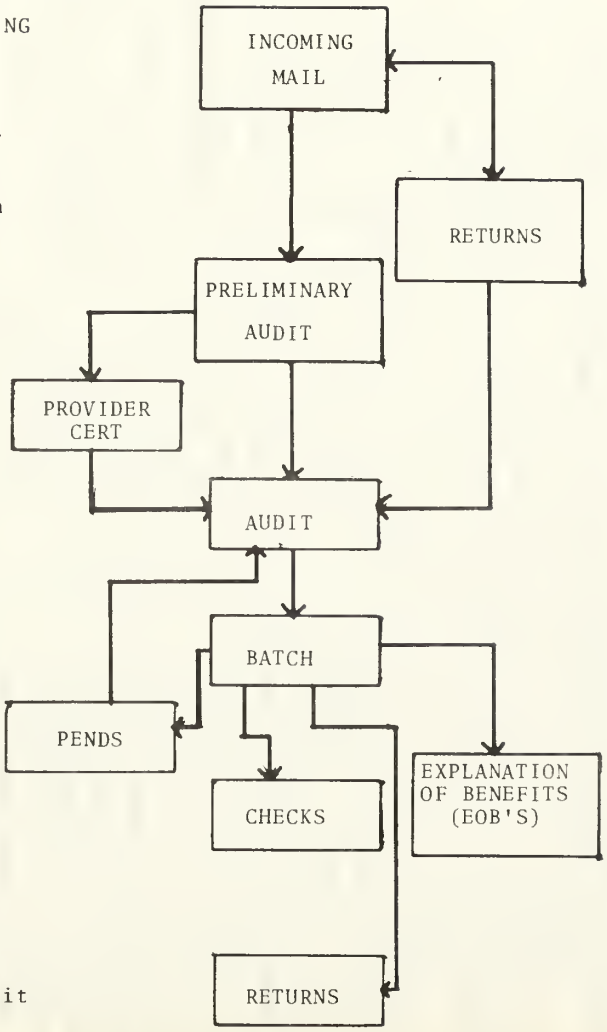
The processed claims are matched to batch output the day following the batch cycle.

Verified payments are mailed as are the EOB's and those claims that must be returned. Claims that are paid or rejected are labled and filed by claim #. Returned claims are held in a pending file.

*Returns are those claims found to be incomplete and not processable. They are returned to sender with a request for the specific items needed. Return letters are computer generated.

**The claim number is composed of a digit for year, 3 digits for Julian day, 5 digits for sequence and a two-place alpha numeric suffix: 3 004 01234-A1.

EOB - Explanation of benefits Statement.



have errors in patient eligibility. That is, clarification in the relationship of the patient to the sponsor, the identification card number, or the beginning or expiration date of eligibility is needed.

Mutual's claims rejection rate is less than one percent. Claims are usually rejected either because care was rendered prior to the beginning eligibility date as shown on the claim form or after the expiration date of the patient's identification card as shown on the claim form. These reasons for rejection account for about 75 percent of all rejections, the remaining rejections caused primarily by the reason that the care provided was not a benefit under CHAMPUS regulations.

In the processing of inpatient claims each claim receives a series of reviews similar to those used by the Blue Cross organization. Itemization on the face of the claim is summarized to determine correctness of the totals. Dates of care must correspond to the number of days being billed and the charge per day must meet the provider's record of room charges supplied to Mutual and recorded in the computer. Ancillary services provided by the hospital are reviewed on the basis of "reasonableness" of the charges for the services rendered. All hospital claims are processed on the basis of billed charges. The patient's deductible is computed based on the length of stay for active duty dependents and on the basis of the patient's co-insurance requirement for retired beneficiaries. This co-insurance feature is a term used by

Mutual to account for the requirement that retired persons must pay 25 percent of all charges for the care that they receive.

The same basic processing system is used for processing non-hospital type claims. Mutual determines whether a physician's charge is his customary charge for similar services and that this customary charge does not exceed the prevailing charge in the locality for similar services. Profiles are maintained on all CHAMPUS physicians and these are periodically reviewed. Once a year the pricing file mechanism is updated to include the most current information on physicians in Mutual's contract territory.

In the actual claims processing procedure, Mutual's system is on a filtration type. All claims pass through the audit staff. Claims that represent special problems are referred to a second audit level, and from that point, are referred to a Medical Review Committee. This committee is composed of registered nurses, senior department personnel, and corporate associate medical directors. The function of the various audit levels is to determine whether or not the patient is an eligible beneficiary and whether the diagnosis and treatment received are proper benefits of the CHAMPUS Program. At one of these audit levels, a claim is released for appropriate payment or rejected. Providers may request a review of decisions through peer reviews at the state level or they may seek a review by OCHAMPUS.

Funds to cover payments to providers or beneficiaries are forwarded by wire by OCHAMPUS to Mutual's depository bank to cover CHAMPUS payments issued. A billing is sent to OCHAMPUS on a weekly basis covering the week's activities. The Mutual system maintains, on-line, eighteen months of patient records. In total, they maintain five years of patient records. Co-insurance and deductible calculations are taken by the computer and are maintained in the patient records. A three year patient deductible record is maintained in an active status in order to prevent duplicate payments.

Reports generated by Mutual's system include a monthly claims activity report, a weekly billing report, and any special reports requested by OCHAMPUS. Internally, reports on auditor productivity, claims distribution listings showing action taken on all items cleared through the computer, and bank reconciliations are generated on an automatic basis by the computer.

C. BLUE SHIELD OF CALIFORNIA

Except for the several geographic areas covered by Mutual of Omaha, most geographic area state medical associations, state Blue Shield organizations, or other similar service agencies or insurance companies process non-hospital type claims. Blue Shield of California is typical of these state organizations [Ref. 6].

Blue Shield receives about 20,000 CHAMPUS claims per week. About 60 percent of these claims are from providers, the

remainder from beneficiaries. Approximately 30 percent of the claims contain some type of error. About 95 percent of these errors can be corrected via telephone calls to the provider. Blue Shield experiences a 20 percent claims rejection rate. Claims cannot be processed and thus must be rejected for one of three main reasons:

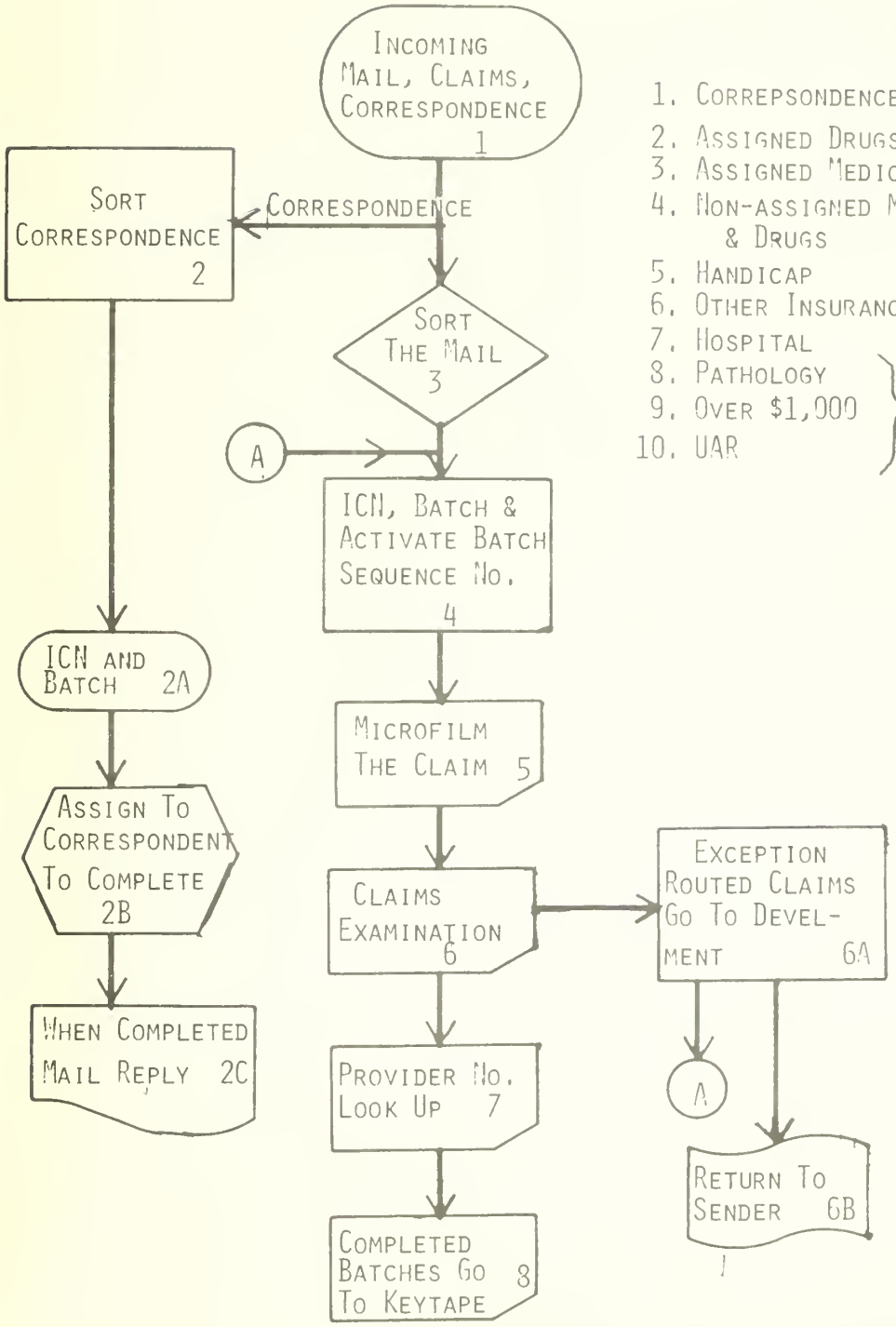
1. The deductible requirements have not been met.
2. The beneficiary is ineligible for treatment.
3. The care received is not a benefit under the CHAMPUS Program.

The Blue Shield claims rejection rate is higher than Blue Cross and Mutual for several reasons. First, Blue Shield handles all types of claims except hospital claims. The outpatient benefits are numerous and, in many cases, not specifically defined. It is felt that many providers, i.e., physicians accept a patient and treat a condition that they consider a benefit. During claim review the condition or treatment is determined not to be a benefit. Another reason for the high rejection rate is thought to be the lack of trained clerical personnel in most physician's offices. Normally, a physician will have one or two nurses in his office. These persons are not fully aware of the CHAMPUS benefits. Still another reason is thought to be that of "we're not certain so we'll submit a claim" reasoning by the dependent.

Exhibit 9, a simplified flow diagram, indicates the processing procedures used by Blue Shield of California. As

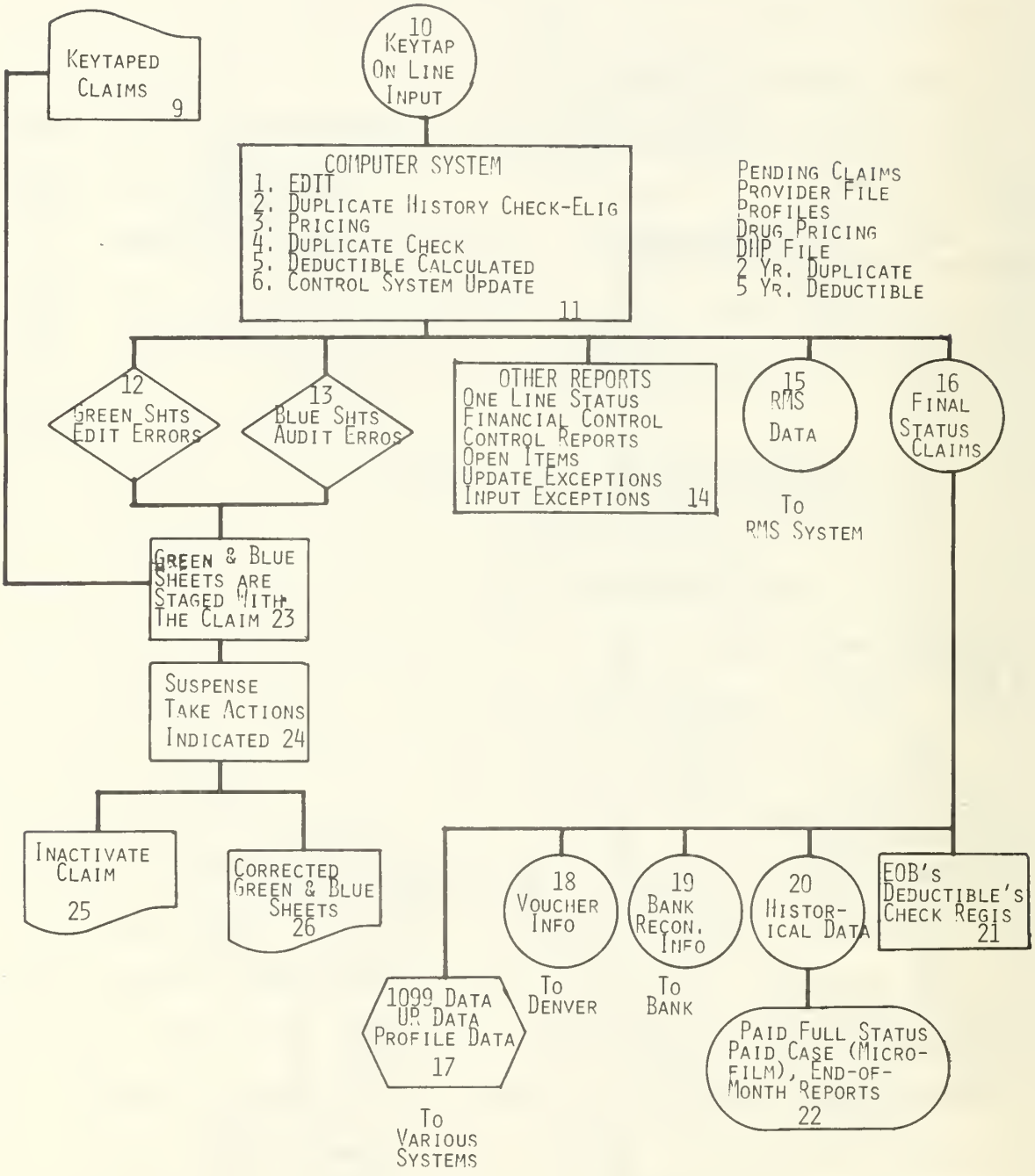
EXHIBIT 9-A

CHAMPUS SYSTEM



1. CORREPSONDENCE	6%
2. ASSIGNED DRUGS	2%
3. ASSIGNED MEDICAL	55%
4. NON-ASSIGNED MEDICAL & DRUGS	28%
5. HANDICAP	1%
6. OTHER INSURANCE	2%
7. HOSPITAL	5%
8. PATHOLOGY 9. OVER $1,000 10. UAR	1%

EXHIBIT 9-B


KEYTAPED CLAIMS 9
10 KEYTAP ON LINE INPUT
COMPUTER SYSTEM
1. EDIT
2. DUPLICATE HISTORY CHECK-ELIG
3. PRICING
4. DUPLICATE CHECK
5. DEDUCTIBLE CALCULATED
6. CONTROL SYSTEM UPDATE
11
PENDING CLAIMS
PROVIDER FILE
PROFILES
DRUG PRICING
DHP FILE
2 YR. DUPLICATE
5 YR. DEDUCTIBLE
12 GREEN SHTS EDIT ERRORS
13 BLUE SHTS AUDIT ERROS
OTHER REPORTS
ONE LINE STATUS
FINANCIAL CONTROL
CONTROL REPORTS
OPEN ITEMS
UPDATE EXCEPTIONS
INPUT EXCEPTIONS 14
15 RMS DATA
To RMS SYSTEM
16 FINAL STATUS CLAIMS
GREEN & BLUE SHEETS ARE STAGED WITH THE CLAIM 23
SUSPENSE TAKE ACTIONS INDICATED 24
INACTIVATE CLAIM 25
CORRECTED GREEN & BLUE SHEETS 26
18 VOUCHER INFO
To DENVER
19 BANK RECON. INFO
To BANK
20 HISTOR-ICAL DATA
EOB'S DEDUCTIBLE'S CHECK REGIS 21
1099 DATA UR DATA PROFILE DATA 17
To VARIOUS SYSTEMS
PAID FULL STATUS PAID CASE (MICRO-FILM), END-OF-MONTH REPORTS 22

the claim is received, it is issued an Insurance Case Number (ICN) composed of one digit for the year, three digits for the Julian day of the year, a batch number, and a claim number within the batch. Prior to the assignment of an ICN, the claims are sorted into one of ten claims classifications used by Blue Shield (See Exhibit 9-A). They are also given a preliminary screening for completeness at this point. All claims are then batched according to classification and an ICN assigned. No more than fifty claims are assigned to the same batch number. After assignment of the ICN the claims are microfilmed and processing begins.

In the claims examination step claims are examined for correctness and completeness. Claims requiring development of missing or erroneous data are separated to a Claims Development Section. All possible errors are corrected by telephoning the provider for the missing information or to obtain the correct data. In case a telephone call cannot clear up the errors, the form is returned to the provider for completion and correction.

After all the data is obtained or corrected, the claims reenter the system. Claims that do not require additional work go to provider look-up where the provider's code is checked to ascertain whether he is a qualified, participating provider. From this point all the claims are collected by batches and sent to San Diego where they are keyed directly to computer tape by Blue Shield's computer services

contractor. The information on the tapes is then fed directly to the Blue Shield computer center in San Francisco via direct wire data link.

Blue Shield, as the Fiscal Administrator for the outpatient CHAMPUS Program in California, pays claims in accordance with the "usual," "customary," and "reasonable" charge concept. This is commonly referred to as a Provider Profile System, and is considered by Blue Shield as one of the most efficient and equitable mechanisms for administering payments to providers and beneficiaries.

On the other hand Blue Cross and Mutual, when processing inpatient claims, administer payments under one of three methods. The first method, a negotiated Per Diem Reimbursement, is not widely used. In this method of reimbursement a per diem figure for each day of covered care is arrived at by negotiation. The per diem rate need not be directly related to hospital charges or costs. Under this method the daily reimbursement decreases as days of hospitalization increase until a lower limit is reached. This method of reimbursement is not used by most hospitals because it is too difficult to justify to regulatory agencies.

The second method used is called Reimbursement Rate Based Upon Hospitals Retail Charges. Retail charges refer to regular room rates and normal billings for special service any patient would pay. These are now construed to mean a price at least equal to, and most probably above, the actual

cost per patient day of providing hospital accommodations. The retail charges are the maximum reimbursable limits. In many instances the "retail charge" is set as an average of all hospital in a given Blue Cross Plan. These rates are normally simple to derive but there is the constant possibility that some hospitals will overcharge. This method of reimbursement is also declining with most hospitals that use it located in the South.

The last, and most commonly used method, is termed Reimbursement Based Upon Hospital Costs. In this method the hospital is reimbursed for actual costs incurred in providing services. This method is a type of negotiated method in that Blue Cross or Mutual and the hospital must agree as to what allowable elements are to be used in calculating the costs. Normally, there is a minimum cost stipulation, called a floor, which is a certain percentage of each size or locational grouping of contracting hospitals. There are also ceilings, or maximum allowable costs, normally stated as a proportion of average costs among hospitals of similar nature and size. A "floor" rewards a hospital with costs which are less than the minimum while a "ceiling" penalizes a hospital with high costs (usually a specialty hospital). This method is amenable to hospitals non-profit status and insures that a hospital will receive amounts adequate to cover expenses. There is, however, some question that this method might encourage inefficiency.

Under the Provider Profile System, a provider's charge is considered an allowable charge if it is his "individual" charge for the service and if it is within the "area range" of charges made by providers in the same community for the same service, or if it is judged to be "reasonable" by local peer review, considering all of the medical facts and circumstances.

The criteria considered in determining allowable charges are individual charges (Usual) and area charge (Customary Range). Individual charge is the amount the provider usually and most frequently charges for a specific service. These charges are not necessarily uniform or static, but may vary among providers and with the passage of time. Area charge is the amount most frequently and most widely charged in a local community by providers for a specific service. These charges reflect factual data on an overall charge pattern existing within a specific and limited geographical area. They tend to cluster about a certain figure which might be statistically identified as the "mean" or the "median." The degree of specialization, population density, as well as other items concerned with the economics of a provider's practice, which may vary from one locality to another, are all taken into account in determining the area charge.

Every charge which a provider makes for services rendered to beneficiaries of Blue Shield-administered programs, and the Company's private business -- as indicated by submitted

claims -- are recorded to his account and stored on the company's computer tapes by provider name and license number, procedure or service rendered, billed charge, and his practicing address. A continuous record is kept of all charges made to the Fiscal Administrator from each provider for services he performs. These charges, over a given period of time, usually one year, are used as the data base in calculating the provider's profile.

The provider's individual charge for each of the services which make up his "profile" are updated annually in order to reflect changes which may have taken place in his pattern of charges. A general profile update is accomplished in July of each year and is based on all billed charges for the preceding calendar year. Thus, the update in July 1974 will be based on all billed charges for the period of January to December 1973.

To calculate the allowed charge, the "individual" charges for a specific service are arrayed from the lowest billed charge to the highest. For example, a provider submitted claims for 41 routine office visits; for ten of these visits he charged $10, for 15 visits he charged $12, and for the remaining 16 visits he charged $15. The median would be that point at which one-half of the 41 visits were charged. In this case, he charged $10 and $12 a total of 25 times and $15 on 16 occasions. Therefore, his individual charge is calculated to be $12. The allowable amount is then determined by

the lesser of the billed amounts, the individual profile, or the area charge. In this case, $12 would be the allowed amount.

Since Blue Shield does not pay claims on the basis of a fee schedule, but under the UCR concept, when the computer prints out a check for payment of an amount below that which was billed by a provider, it signifies that the billed charge was above the provider's individual charge or above the area range. It does not necessarily indicate that the charge was not reasonable as it may be justified concerning the special circumstances of that particular case.

Any provider who believes that his charges have been unfairly reduced, or that circumstances justify an increased fee in certain cases, has the right to request review by an Advisor of his specialty, or he can avail himself of the advice and assistance of his local peer review committee that each county and district medical society has appointed for that purpose. In recent Blue Shield history few providers have requested more than one review of disputed payments.

In no case, however, can a provider bill the patient for the difference between the amount he claimed and the amount he received. One of the provisions of agreeing to accept CHAMPUS patients is that of the full payment concept. Under this concept, the amount determined by the fiscal administrator to be the reasonable charge for the service provided is considered as payment in full. A physician agrees to this

concept when he signs and submits a claim. The only exceptin to this concept is for those charges that relate to a case which is not a proper benefit of CHAMPUS.

Under the terms of the existing contract that Blue Shield has with the Federal Government, one of the contractual obligations is that CHAMPUS payments conform to the concept of usual, customary, and reasonable, and that payments made to, or on behalf of, CHAMPUS beneficiaries, not be higher than payments made to, or on behalf of, the company's policyholders and subscribers, when services are comparable and furnished under comparable circumstances. The UCR is, as a matter of policy, used in determining payable amounts by Blue Shield in the operation of its private business as well as in the operation of its government business.

Several years ago, Blue Shield, in cooperation with its parent organization, the California Medical Association, conducted a Relative Value Study. This study formalized the procedures used by a physician and assigned each procedure a code number. Each procedure was also assigned a value in terms of units. The definition of a unit of value as used in the RVS is vague. For example, the 1969 RVS states that the unit value for a brief evaluation, history, examination and/or treatment for a new patient is 20.0. For an established patient a brief examination, evaluation and/or treatment of the same or new illness has a unit value of 12.0. The only difference in the two is the new patient receives a history. Does the taking of a medical history have a value of 8.0, the

difference in the above values? One cannot say for certain because an initial limited history and physical examination for a new patient has a unit value of 30.0.

Thus one must conclude that the concept of unit value centers around the time involved, the types of services provided, the types of and the amount of supplies and materials used, the use of paramedical personnel (nurses) and the amount of knowledge or expertise that must be utilized in providing the service.

A unit of value was further assigned a dollar amount. It is from this study that the physician's reasonable fee is computed. For example, an office visit may be assigned the RVS code number 9004. Assume that the usual value for this procedure is four units based on the time involved, the complexity of care provided, and all other factors. Further assume a unit of value is worth $6. Thus, a "reasonable" fee for an office visit is computed to be $24. Using this system permits Blue Shield to compute "reasonable" fees in those special cases where the usual or customary fee is not applicable.

It is important to note that an individual physician's "usual" fee rate may be influenced by his offering of "professional discounts." These discounts, normally offered to other physicians and other medical personnel, tend to lower his "usual" fee since they are part of the overall collection of billed charges that Blue Shield maintains in the Provider

Profile System. It is also interesting to note that, on occasion, a provider can influence his "usual" fee by moving the location of where he provides the service. Thus, by moving from an area close to a hospital to an area further removed from the hospital he may be able to raise his usual fee. The effect of such a move would not, however, be reflected in the payments he receives until a year later because of the time lag in adjusting the pricing mechanism in Blue Shield's system.

An interesting feature of the Blue Shield System is that the computer automatically generates audit sheets. A Green Sheet Audit, titled CHAMPUS CORRECTIONS, printed appropriately on green paper, is generated when errors are encounted in the patient history data. That is, errors are found in Items one through thirteen of the claim form. These Green Sheet Audits, a sample of which is shown in Exhibit 10, are collated with the claim containing the errors. When the error has been corrected, the audit sheet's corrections are entered into the computer through on-line cathode ray tube and control units.

Blue Sheet Audits, titled CHAMPUS SUSPENSION LISTING, printed on blue paper, are automatically generated when provider identification and/or pricing errors are encountered. These errors are corrected and fed into the computer in the same way as are the Green Sheet Audits. Uncorrectable data on either of the audit sheets causes the claim to be returned

EXHIBIT 10

CHAMPUS CORRECTIONS

02/04/75 PAGE 2 OF 2 1

01175

ACTION	ICN	SPONSOR NUMBER	CLERK	
	502771305 5	539244845		FIRST RECORD
	502771305 5	539244845		SECOND RECORD SEE CORRECTIONS

ACT	LINE	SERVICE NUMBER	SOCIAL SECURITY NUMBER	SPONSOR LAST NAME	FI	MI	STAT	BOS	GRADE	CLERK
A0	00	019416694	539 24 4845	HARRIS	E	C	2	1	E	E67C
		01	02	03	04	05	06	07	08	09

ACT	LINE	ASN	TOTAL CHARGE	PATIENT PAID	OTHER INSURANCE	DEDUCTIBLE	CERT	STAT	BOC	DIAG NO
A6	00	V	LINES 08	19 50	00	00	1	2		381
		11	12	13	14	15	16	17	18	19

ACT	LINE	PATIENT FIRST NAME	MI	REL	DATE OF BIRTH	BEGIN ELIG DATE	END ELIG DATE	HANDICAP	TYPE	FACIL
A1	00	YAEKO		1	08 21 27	05 22 72	05 22 78			
		21	22	23	24	25	26	27	28	29

ACT	LINE	PATIENT STREET ADDRESS	CITY	STATE	ZIP CODE
A2	00	787 ELLEN LN	EL CAJON	CA	92021
		31	32	33	34

ACT LINE	DATE FILLED / DATE OF SERVICE	PRESCRIPTION NO / PROCEDURE NO	REFILL MOD	AMOUNT BILLED	PROF FEE TOS	QUAN MULT SVC	PAID BY OR DUE FROM PATIENT	ACQUISITION COST	PROVIDER NUMBER	PROV NAME	PROV CODE	N C MSG	DRUG CODE
*A907	*11 14 75	99070		2 50	C	01.0			*	*	51		9988
	81 82		83	84	85	86	87	88	89	90	91	92	93
*A908	*11 14 75	99070		2 50	C	01.0			*	*	51		9988
	81 82		83	84	85	86	87	88	89	90	91	92	93
	81 82		83	84	85	86	87	88	89	90	91	92	93
	81 82		83	84	85	86	87	88	89	90	91	92	93
	81 82		83	84	85	86	87	88	89	90	91	92	93
	81 82		83	84	85	86	87	88	89	90	91	92	93

027 713 DETAIL TOTAL ▶ 50 00 CLAIM CONTAINS 18 EDIT ERROR(S) INDICATED BY ASTERISKS.

REMARKS ▶
(DO NOT KEYTAPE)

to whomever originally submitted it to Blue Shield. Exhibit 11 is a sample of this form. When all of the indicated corrective actions have been taken, the carbon copies of these audit sheets are filed with the batched claims. The originals of the audit sheets are disposed of in a recycling process.

One of the main reports generated by the Blue Shield system is a "one-line status report." This report is generated at the completion of each batch run and provides Blue Shield with the status of every claim in process or completed during the run. A sample page of the report is shown in Exhibit 12. In reading the report the notation "pended claim" in the check number column indicates a claim in which some data is missing or is incorrect and, as a result, a Green Sheet Audit or a Blue Sheet Audit was printed. Such claims are held in an active status in the computer for 30 days. The notation "delete" in the Check Number column indicates a claim which has been rejected by the system.

Blue Shield keeps a microfilm record of all claims for two years and retains microfilm records of processing actions for five years. Samples of these two microfilm records titled "CHAMPUS PAID FULL LISTING - DECEMBER 1974" and "CHAMPUS ALPHABETIC CROSS REFERENCE" are shown in Exhibits 13 and 14 respectively. These files are necessary to keep track of deductibles and co-insurance to prevent duplicate claims and to provide a complete family history as required by CHAMPUS regulations.

EXHIBIT 11

C3136 CALIFORNIA BLUE SHIELD

CHAMPUS SUSPENSE LISTING

01-14-75 PAGE 04 OF 4 1

ACT	ICN	SPONSOR NUMBER	CLERK
	500980002 9	558360861	

ACT	LINE	SPONSOR LAST NAME	FI	MI	SERVICE NUMBER	SOCIAL SECURITY NO	CLERK	HANDICAP	TYPE	FACIL
	00	DAVIS	O	J		558 36 0861	C21S			

ACT	LINE	ASN	PATIENT FIRST NAME	MI	DEDUCTIBLE	DIAG	BRK	TOTAL BILLED	PATIENT PAID	OTHER INS	
	00	V	NORMA	J	0 00	508		LINES 17	0 00	0 00	P;00 C;44

ACT	LINE	ACT	DATE FILLED / DATE OF SERVICE	PRESCRIPTION NO / PROCEDURE NO	AMOUNT BILLED	N/R TOS	MULT SERV	PROV CODE	PROVIDER NUMBER	PROV NAME	N/C MSG	DRUG CODE	PRICE ADJ	ACT
	16	A9	11 25 74	99070	28 00	C	1 0	51	00C123680	RO	24	9988	0 00	N6
	17	A6	10 10 74	90050	11 00	1	1 0	51	00C123680	RO	40	9005	10 50	

Line 16:

	REJECT REASON	DUPLICATE ICN	DATE PAID	DUPLICATE ICN	DATE PAID	ADD DUP
21K	M/P - R/C - - - - MR					*

	LOC	LEVEL 1	LEVEL 2	LEVEL 3	PRICING MESSAGE
0 71	01	0 00C	0 00	0 00	BY REPORT PROCEDURE ON RVS FILE

Line 17:

	REJECT REASON	DUPLICATE ICN	DATE PAID	DUPLICATE ICN	DATE PAID	ADD DUP
21K	- - - - -					

	LOC	LEVEL 1	LEVEL 2	LEVEL 3	PRICING MESSAGE
0 71	01	11 00	10 50	11 40	REAS AT LEV1/CUT AT LEV2 /REAS AT LEV3/ PAY LEVEL 2

009 800

EXHIBIT 12

HHOP310F-OL CYCLE DATE 01/07/75 CHAMPUS ONE LINE STATUS REPORT FRAME 1533

SPONSOR'S LAST NAME	PATIENT'S FIRST NAME	M I	SEX REL	SPONSOR NUMBER	S T	CL TY	CLAIM NUMBER	PRE LOC	NUM DYS	VEND NAME	CKDT MMDD	CHECK NUMBER	CHECK AMOUNT	BILLED AMOUNT	PAT PAID AMOUNT	DEDUCT-IBLE	CO-INS
ZOECKLEIN	WALTER		4	301050902	2	DV	431850002A	426	121	PEARS	1219	2234120	33.83	45.12	11.27		11.25
ZOECKLEIN	WALTER		4	301050902	2	MV	452571023A	016	135	LOMA	1205	2212370	8.44	12.50			2.83
ZOELNER	ERIC		3	498123960	2	MV	434372447A	4061		SCHLU	0107	0	15.00	70.00		50.00	5.00
ZOELNER	ERIC		3	498123960	2	MV	434372447B	4061		SCHLU	0107	0	97.50	180.00		50.00	32.50
ZOGORSKI	DOROTHY		1	580382138	2	MV	432372803A	336	235	SCHNE	1205	3390725		12.00		12.00	
ZOGORSKI	DOROTHY		1	580382138	2	MV	432372803B	336	135	SCHNE	1205	2214526	36.75	99.00		50.00	12.25
ZOHRLAUT	SHIRLEY	R	1	555526036	2	MP	432972345	415	121	MAGER	1213	DELETE		59.75			
ZOHRLAUT	SHIRLEY	R	1	555526036	2	MP	435830015A	3361		PARKV	1219	2238178	18.69	22.25			5.56
ZOHRLAUT	SHIRLEY	R	1	555526036	2	MP	434540137A	016	121	SPECI	0107	0	19.88	28.50			6.62
ZOLBY	MARGARET	C	1	044275001	2	MV	434672340A	016	212	ALLEN	1230	2248835	24.00	101.50	77.50	28.50	17.25
												2248836	27.75		REFUND TO PATIENT		
ZOLBY	MARGARET	C	1	044275001	2	MV	435074611A	3161		WERNE	0107	0	30.00	60.00			10.00
ZOLBY	EUGENE		3	044275001	2	MP	434540137A	026	121	SABRA	1219	3530678		16.50		16.50	
ZOLBY	MARGARET	C	1	044275001	2	MV	438171531A	0161		AMERI	0107	0	31.13	48.00			10.37
ZOLLER	TAMMY	A	2	575324903	1	MV	435771243B	0162	7	SANTA	1231	2253290	112.50	175.00			37.50
ZOLLER	TAMMY	A	2	575324903	2	MV	435771243A	0161	7	SANTA	1231	3850281		15.00		15.00	
ZOLLINGER	JANICE	L	1	560228976	1	MV	435479622A	016	128	SMITH	1212	2224638	7.50	60.00		50.00	2.50
ZOLLO	ERNEST	G	4	050189237	2	MV	432930223A	346	112	BUNKS	1230	2245813	412.50	600.00			137.50
ZOLLO	JACQUELINE	M	1	050189237	2	MV	434779706	314	518	RYAN	1220	PENDED CLAIM					
ZOMPETTI	GLORIA	R	1	561667682	1	MV	432370004B	346	228	ORANG	1212	2224058	865.00	900.00			
ZOMPETTI	GLORIA	R	1	561667682	2	MV	432370004A	346	228	ORANG	1212	3460351		15.00		10.00	
ZOMPETTI	GLORIA	R	1	561667682	1	MV	434772843	013	118		1220	PENDED CLAIM		170.00			
ZOOK	JAMES		3	526013084	1	MV	432531115A	316	128	LOMPO	1212	2228900	12.60	16.80			4.20
ZORBLA	MARY	J	1	462301865	1	MV	434771839A	336	112	GELLI	1230	2249064	58.50	100.00			19.50
ZORBLA	MARY	J	1	462301865	1	MV	434771848A	4061		ROSEM	0107	0	73.65	107.00			24.50
ZORBLA	MARY	J	1	462301865	1	MV	435480035A	3161		CLEM	0107	0	75.00	130.00			25.00
ZORBLA	MARY	J	1	462301865	2	MV	436470042	0140		MARTI	0107	PENDED CLAIM		585.00			
ZORBLA	MARY	J	1	462301865	1	MV	430970848A	406	118	NAMIH	1223	2242854	506.10	825.00			188.70
ZORBLA	MARY	J	1	462301865	1	MV	433772624A	016	128	HOIEN	1212	2225779	78.98	115.00			26.32
ZSEDENY	DORA		1	222184320	2	MV	430878504A	456	132	HART	1209	2218627	13.72	179.10	64.10	41.96	3.42
ZUBAK	IVAN	S	4	298121423	2	MV	432980187	314	232	JOHNS	1206	PENDED CLAIM		250.00			
ZUBER	DORI		2	516308044	1	MV	433079623A	0162	7	FRENC	1231	3850093		22.80		22.80	
ZUBIATE	MICHELE		2	550817293	2	MV	435470932A	016	135	LEGOM	1205	2213762	77.78	120.00			25.92
ZUBIATE	MICHELLEY		2	550817293	1	MV	435770210	3331		FRENC	0107	PENDED CLAIM		16.00			

EXHIBIT 13

485
FILM DATE JANUARY 01, 1975 CHAMPUS PAID FULL LISTING - DECEMBER 1974 FRAME 7211

SPONSOR-# ALTERNATE-# SPONSOR-NAME BOS GRD STAT DEDUCT-YEAR-SET DEDUCT-YEAR-SET DEDUCT-YEAR-SET DEDUCT-YEAR-SET
485421610 003198357 MAASSEN LR 4 0 ACT 60.00 74-75 15.00 73-74 50.00 72-73

PATIENT-NAME BIRTHDTE REL HDCAP ELIGDATE EXPRDATE DEDUC-YEAR-SET DEDUC-YEAR-SET DEDUC-YEAR-SET DEDUCT-YEAR-SET
CAROLYN M 01-28-41 1 01-30-72 01-30-78 60.00 74-75 15.00 73-74 50.00 72-73

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4162-801-024 04-11-74 M-V 2 626 27.50 B 27.50 ADAMS
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
06-21-74 1720443

DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
04-11-74 1.0 1 9019 9001500 69 A6 00C293850 51 20.00 35.00 36.50 27.50 20.00 40

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4162-801-028 05-14-74 M-V 2 626 815.00 B ADAMS
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
06-21-74 1939484 615.00
DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
05-14-74 1.0 2 4614 5815000 69 A6 00C293850 01 533.30C 560.00 580.40 690.00 533.30 40
05-14-74 -.50 2 4612 5812050 69 A6 00C293850 01 66.70C 75.00 72.60 100.00 66.70 40
05-14-74 1.0 2 4512 5741050 69 A6 00C293850 01 24.00C 15.00 26.20 25.00 15.00 40

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4178-711-244 05-14-74 M-V 2 625 163.00 B LAUDE
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
07-15-74 1971100 128.00

DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
05-14-74 1.0 3 4614 5815080 69 A6 00C157390 03 130.00 128.00 115.40 163.00 128.00 40

CLAIM-NUMBER END-CARE CLM-TYP BASIS DIAG CERTS AMT-BILL OTHERINS PAT-PAID PA-MTHD AMT-DED SET CO-INSUR PROV-NAM
4199-798-274 05-14-74 M-V 2 629 168.00 B LIPPM
CHECK-DATE CHECK-1-# CHECK-1-AMT CHECK-1-EOB CHECK-2-# CHECK-2-AMT CHECK-2-EOB
07-25-74 1992882 160.00

DATE-SER MULT TOS 64RVS 69RVS PC-ENT OA MA PROV-NUM CODE LEVEL-1 LEVEL-2 LEVEL-3 AMT-BILL AMT-DED AMT-PABL EOB
05-14-74 11.0 7 4614 5815040 69 A6 00G144830 02 160.00C 164.80 168.00 160.00 40

EXHIBIT 14

FILM DATE: 01/25/75 CHAMPUS ALPHABETIC CROSS REFERENCE FRAME 19882

SPONSOR NAME	BOS	SPONSOR SOC SEC NO	SPONSOR SERVICE NO	SPON STAT	INEL	SPONSOR ADDRESS	70-71	FAMILY DEDUCTIBLE 71-72	72-73	73-74	74-75
DEPENDENT NAME		DEPENDENT BIRTHDATE	AGE IMD	SEX REL	70-71	DEPENDENT DEDUCTIBLE 71-72	72-73	73-74	74-75	DEPENDENT ID CARD NUM	ELIGIBILITY DATES BEGIN	END	OTHER INS	TELEPHONE NUMBER
MAASJR	E	R 2	000053905											
OPAL		V 3/24/36	1											
MAASS	R	E 1 0050554839	000337454	RET		915 1/2 ELM AVE							50.00	50.00 98.40 14.00
						LONG BEACH		CA 90813						
ROBERT		E 7/12/11	4		50.00	50.00 50.00	14.00	1043579		8/20/71	12/31/99	1		
ROBERT		3/11/56	3			48.40		GL865003		5/09/73	03/10/77	1		
MASS	M	O 8 023888185		RET		6973 ST MARK CT								100.00 17.35
						SANTA ROSA		CA 94501						
TRICIA		8/28/73	2			50.00	17.35	23888185D		9/01/73	08/28/91	1		
SHAWN		5/ 3/71	2			50.00		23888185D		9/01/73	05/03/89	1		
MAASS	F	K 4 3657648924		DEC		23566 MACKERAL AVE							50.00	50.00 50.00 50.00 28.00
KAREN		B 9/25/61	2					N13445354		6/24/73	08/01/79	1		
HELEN		4/12/41	1		50.00	50.00 50.00 50.00	28.00	N13445353		6/24/71	08/01/77	1		
STEVEN		M 4/12/63	3					N13435387		6/24/73	08/01/79	1		
MAASSEN	R	R 4 385337081	000603843	ACT										
MARY		K 1/19/45	1											
MAASSEN	L.R	4 485421610		ACT		373 C BERGIN DR								27.50
						MONTEREY		CA 93940						
CAROLYN		M 1/28/41	1			27.50		N10222256		1/30/72	01/30/78			

Blue Shield receives payment directly from OCHAMPUS in the same way as Mutual does. Once a week an estimate of the dollar amounts to be paid is wired to OCHAMPUS. OCHAMPUS responds by depositing funds in Blue Shield's depository bank. The estimates are followed up by a more detailed invoice and OCHAMPUS makes the appropriate adjustments in subsequent payments. Copies of computer tapes of claims processed are also sent to OCHAMPUS.

Blue Shield reports that it is currently able to process and make payment on over 80 percent of the CHAMPUS claims in five to seven days. The system will hold a "pended" claim for thirty days and will then generate a special follow-up report. Further action is taken if no response is received by the end of 45 days.

CLAIMS PROCESSING - OCHAMPUS

Upon completion of the claims processing by one of the 47 fiscal administrators/hospital contractors, a check is sent to either the provider or to the beneficiary as applicable. The contractor then submits a bill to OCHAMPUS for reimbursement. This chapter will examine the process by which OCHAMPUS adjudicates the contractor's claim [Ref. 7].

A. CONTRACTOR ADVANCES

As noted earlier, the contractor begins the reimbursement procedure by telephoning OCHAMPUS for an advance of funds to offset the checks being mailed out. This procedure, referred to as a wire or telegram in the preceding chapter, is received in the Finance and Accounting Division of the Contract Management Directorate of OCHAMPUS. Whomever answers the telephone records each call on a preprinted "Routine and Transmittal Slip," Optional Form 41 shown in Exhibit 15. The name of the person calling, the state contractor he represents, the amount requested, the invoice number, and the period covered are carefully noted and are repeated back to the caller to verify accuracy. The person taking the call then signs and dates the slip. Additionally, the exact time of the call is noted on the form.

During the call the person in the F&A Division checks a blackboard euphemistically termed the "Advances Status Board." If a state contractor has two or more outstanding

EXHIBIT 15

ROUTING AND TRANSMITTAL SLIP		ACTION
1 TO STATE:	INITIALS DATE	CIRCULATE COORDINATION
2 PERSON CALLING:	INITIALS DATE	FILE INFORMATION
3 PARTIAL PAYMENT NO:	INITIALS DATE	NOTE AND RETURN PER CONVERSATION
4 VOUCHER NUMBER:	INITIALS DATE	SEE ME SIGNATURE

REMARKS

AMOUNT $ _____

INVOICE NUMBER:

PERIOD COVERED:

Do NOT use this form as a RECORD of approvals, concurrences, disapprovals, clearances, and similar actions

FROM	DATE
	PHONE

OPTIONAL FORM 41
AUGUST 1967
GSA FPMR (41CFR) 100-11.206

* GPO : 1969 O-352-829 5041-101

1

advances, that is, advance payments that have not been substantiated by an invoice, they are advised that no further advances will be processed until the oldest of the advances have been invoiced to OCHAMPUS. If their state is not on the board their advance funds request is processed. The processing procedure begins with the assignment of a Voucher Number. This number is composed of the fiscal year plus a four digit consecutive code. For example, 75-1818 represents the 1,818th voucher for Fiscal Year 1975. Next a Standard Form 1034, Public Voucher for Purchases and Services Other Than Personal, is prepared. This form is shown in Exhibit 16. These forms are collected and taken to the Fitzsimmons Army Medical Center Disbursing Office daily at 2:00 P.M. This office processes the vouchers, sends the necessary data to the OCHAMPUS Computer Operations Division for check preparation, and returns to collect the prepared checks the following day.

When the OCHAMPUS F&A personnel appear at the Disbursing Office with the next batch of vouchers, they pick up the completed vouchers and checks from the preceding day's batch. These checks are taken immediately to the branch bank located on the FAMC grounds where they are deposited in a special account. Special deposit slips listing the voucher numbers and check amounts are prepared and signed by the bank manager. At 3:00 P.M. that same day the checks are taken by special bank messenger to the main bank office in downtown Denver. Early the next morning the bank sends the funds

Standard Form No. 1034 7 GAO 5000 10-14 114-06	**PUBLIC VOUCHER FOR PURCHASES AND SERVICES OTHER THAN PERSONAL**	VOUCHER NO.
U.S. DEPARTMENT, BUREAU, OR ESTABLISHMENT AND LOCATION **DEPARTMENT OF THE NAVY**	DATE VOUCHER PREPARED CONTRACT NUMBER AND DATE REQUISITION NUMBER AND DATE	SCHEDULE NO. **PAID BY**
PAYEE'S NAME AND ADDRESS		DATE INVOICE RECEIVED DISCOUNT TERMS PAYEE'S ACCOUNT NUMBER
SHIPPED FROM	TO	WEIGHT / GOVERNMENT B/L NUMBER

NUMBER AND DATE OF ORDER	DATE OF DELIVERY OR SERVICE	ARTICLES OR SERVICES (*Enter description, item number of contract or Federal supply schedule, and other information deemed necessary*)	QUANTITY	UNIT PRICE COST	UNIT PRICE PER	AMOUNT (1)
(Use continuation sheet(s) if necessary)		**(Payee must NOT use the space below)**			**TOTAL**	

PAYMENT:	APPROVED FOR	EXCHANGE RATE		
☐ COMPLETE	=$	=$1.00	DIFFERENCES	
☐ PARTIAL	BY[2]			
☐ FINAL				
☐ PROGRESS	TITLE		Amount verified; correct for	
☐ ADVANCE			(*Signature or initials*)	

Pursuant to authority vested in me, I certify that this voucher is correct and proper for payment.

(*Date*) (*Authorized Certifying Officer*[2]) (*Title*)

ACCOUNTING CLASSIFICATION (Revised 7-65) (Appropriation Symbol must be shown; other classification optional)

Appropriation Symbol and Subhead	Object Class	Bureau Control and Suballot. No.	Auth. Acctg. Activity	Type	Property Acctg. Acty.	Cost Code	Amount

I.R. No's

PAID BY	CHECK NUMBER	ON TREASURER OF THE UNITED STATES	CHECK NUMBER	ON (*Name of bank*)
	CASH $	DATE	PAYEE[3]	

[1] When stated in foreign currency, insert name of currency.
[2] If the ability to certify and authority to approve are combined in one person, one signature only is necessary; otherwise the approving officer will sign in the space provided, over his official title.
[3] When a voucher is receipted in the name of a company or corporation, the name of the person writing the company or corporate name, as well as the capacity in which he signs, must appear. For example "John Doe Company, per John Smith, Secretary", or "Treasurer", as the case may be.

PER

TITLE

☆ U. S. GOVERNMENT PRINTING OFFICE 1970—366-376

out over the Federal Reserve System's Bank Wire System, a direct telegraphic wire system. The funds go directly to the contractor's depository bank for deposit and advice. The latter term means that someone in the receiving bank will notify the contractor of the receipt of funds. (It should be noted that each bank wire costs the OCHAMPUS command $4.50. Over $600 per month is spent on these bank wires.)

When the completed vouchers are returned to the F&A Division, the appropriate entries are made in the accounting ledgers to record the commitment of the funds. The average processing time for advances is thus about 2.5 days from receipt of the telephone request for funds to actual receipt of the funds by the contractor.

B. CONTRACTOR INVOICES

As a follow-up procedure, each contractor is required to submit an invoice and a computer tape of all claims included in the invoice period. Included in the invoice package is a Control Listing which provides, in summary form, the total number of claims by claim category, i.e., Physician, Hospital, Drug, Handicapped, etc., and the total professional charges for each category of claim. Exhibit 17 is an example of such a control listing. Copies of actual invoices were not available from OCHAMPUS or the contractors previously discussed.

EXHIBIT 17

MC508 CONTROL TOTALS FOR IOWA STATE NO. 14 01/04/75

VCU-NR 751818 INV-NR 000216 PHY/HOSP/DEN = 15,558.02 HDCP = .00 DRUGS = 2,029.78

TOTAL RECORD COUNT	TOTAL LINE ITEMS	TOTAL PAID BY PATIENT	TOTAL AMOUNT DUE FROM GOVERNMENT	TOTAL AMOUNT REIMBURSEMENT PATIENT OR SPONSOR	TOTAL	DIFF.
440	438	5,551.46	13,279.82	4,307.98	17,587.80	.00

Upon receipt of an invoice package the OCHAMPUS Mail Room initiates a CHAMPUS Form 174, OCHAMPUS Voucher Transmittal, by entering an internally controlled batch number and the date received. The same information is placed on a label which is attached to the reel of computer tape. The original of the Form 174, shown in Exhibit 18, is sent to the Finance and Accounting Division with the contractor's Control Listing and the Invoice. The copy of the form, which is printed on yellow paper, is sent with the computer tape to the OCHAMPUS Computer Operations Division.

The Finance and Accounting Division, upon receipt of their portion of the invoice package, completes the data on the Voucher Transmittal using the data on the invoice and the control listing. They also add the Voucher Number. This Voucher Number will be the same one that was used in the processing of the contractor's request for advance funds, except that it will have a Roman numeral suffix. For example, the voucher number cited above was 75-1818. The Voucher Number used for the follow-up incoice would be 75-1818(II) signifying the second use of that number. During the process of completing the Voucher Transmittal form the beginning and ending dates of the invoice are carefully compared to the dates of the period covered on the Routing and Transmittal Slip and the SF 1034 prepared during the processing of the request for advance funds.

EXHIBIT 18

OCHAMPUS VOUCHER TRANSMITTAL

BATCH NUMBER (1–4)

DATE RECEIVED (Y Y M M D D)

CARD ID (★ 1)

CONTRACT NUMBER (2 3 4 5 6 7)

FISCAL YEAR & VOUCHER NUMBER (8 9 10 11 12 13)

FM STATE CODE (14 15)

INVOICE DATES — BEGINNING (Y Y M M D D) (16 17 18 19 20 21) — ENDING (Y Y M M D D) (22 23 24 25 26 27)

INVOICE NUMBER (28 29 30 31 32 33)

CLAIM RATE ADMIN FY

PHYSICIAN / DENTAL or HOSPITAL TOTAL $ (34 35 36 37 38 39 40 41 42) CR

PHYSICIAN / DENTAL or HOSPITAL CLAIMS $ (43 44 45 46 47) CR

PRESCRIPTION TOTAL $ (48 49 50 51 52 53 54) CR

PRESCRIPTION CLAIMS (55 56 57 58) CR

HANDICAP TOTAL $ (59 60 61 62 63 64 65 66) CR

HANDICAP CLAIMS (67 68 69 70) CR

FM PROCESSING DATE (Y Y M M D D) (71 72 73 74 75 76)

DATE BALANCED (Y Y M M D D)

CHAMPUS FORM 174 PREVIOUS EDITIONS OF THIS FORM ARE OBSOLETE.

The established claim rate used to compute the contractor's administrative costs is also entered on the form. This rate, determined by past experience and by contract provisions, is normally a flat rate of a certain amount per claim. Occasionally, when a contractor has a new contract or has changed its processing procedures, a Provisional Claim Rate is used. This rate is based on the number of claims expected to be processed and the assets, people and equipment needed to do the processing. At the end of the year this rate will be audited by HEW auditors and, if indicated, appropriate adjustments will be made in the rate. Five states have provisions in their contracts that direct them to report actual direct claims processing costs for the period covered. These states are California, Washington, Connecticut, Wisconsin, and Idaho. Why these five states are treated differently was not explained by the OCHAMPUS officials. It was pointed out, however, that the direct costs, when translated into a claim rate, are quite comparable to the amounts paid to the other fiscal administrators.

When the Voucher Transmittal has been filled out, it is sent back to Data Processing. The invoice and the contractor's Control Listing are retained by the F&A Division for later use. In order to keep up with the workload the above steps for each invoice package must be completed by 3:00 P.M. each day. At this point it should be noted that the F&A Division has only eight persons and must process an average of ten

advance payment requests and 20 invoice packages per working day.

At the Computer Operations Division the completed original Voucher Transmittal information is keypunched onto a card which will be used as a "header" to the computer tape. During the night the header cards and the computer tapes are run through the computer where the computer tapes are balanced to the invoices, and at the same time, edited for errors. Occasionally during a computer run, a tape is rejected. Rejections are typically encountered because the contractor has modified his coding system and has not informed OCHAMPUS, or the contractor's claims processing computer operations cycle did not coincide with the financial cycle indicated on the invoice. When the latter occurs, record count on the tape will not match record count on the header card and, to save processing time, the tape is rejected by the OCHAMPUS computer.

The following morning the F&A Division receives a list of processed and rejected voucher invoices. The processed vouchers printout is shown in Exhibits 19 and 20. The Control Listing is compared with the "Summary By Fiscal Year and Branch" part of the Voucher Listing to ascertain correctness of totals. The "Summary by Branch" part of the processed Voucher Listing is used to calculate administrative costs and will be discussed in a later section. Accompanying each processed Voucher Listing is an "Edit Error List." Edit errors are of two types. A "Hard" edit error, shown in

EXHIBIT 19

VOUCHER PRINTOUT

MC14P L02D 24/04/75 PAGE 1

IOWA STATE NO. 14

VOUCHER NUMBER 75-1818 SUMMARY BY FISCAL YEAR & BRANCH

FIS. YR.	BR. SV.	CLAIMS	HOS. DAYS	AMT. DUE GOVT
2122020	06-4075 P8400-2572 FIC 841214.12000.000 SO5114			
72	ARMY	2		39.50
TOTAL FY 72		2		39.50
* *				
2132020	06-5075 P8400-2572 FIC 841214.12000.000 SO 5114			
73	ARMY	5		149.25
TOTAL FY 73		5		149.25
* *				
2142020	06-8030 P8400-2572 FIC 841214.12000.000 FO5114			
74	ARMY	36		296.20
	MARINE	1		175.00
	NAVY	12		669.96
	NAVY & MC	13		844.96
	AIR FORCE	20		823.97
	VET ADMIN	2		69.75
TOTAL FY 74		71		2,034.88
* *				
9750100.6300	63-1303 P6300-2572 FIC 630000.12000.000 SO5114			
75	ARMY	124		6,156.63
	MARINE	17		1,341.25
	NAVY	96		3,714.13
	NAVY & MC	113		5,055.38
	AIR FORCE	85		2,817.20
	PHS	4		99.89
	VET ADMIN	34		1,035.07
TOTAL FY 75		360		15,364.17
	TOTAL STATE	438		17,587.80

EARLIEST DATE OF CARE 72 02

LATEST DATE OF CARE 75 03

EXHIBIT 20
VOUCHER PRINTOUT

MC14P L03D 24/04/75 PAGE 2

IOWA STATE NO. 14

VOUCHER NUMBER 75-1818 SUMMARY BY BRANCH

FIS. YR.	BR. SV.	CLAIMS	HOS. DAYS	AMT. DUE GOVT.
9750100.6300	63-1303	P6300-2572	FIC 630000.12000.000	SO5114
7.50 X ARMY		167		1,252.50
7.50 X NAVY & MC		126		945.00
7.50 X AIR FORCE		105		787.50
7.50 X PHS		4		30.00
7.50 X VET ADMIN		36		270.00
7.50 TOTAL STATE		438		3,285.00

COMBINED PROFESSIONAL & ADMIN COSTS FOR VOUCHER FY

ARMY	7,409.13
NAVY & MC	6,000.38
AIR FORCE	3,604.70
PHS	329.89
VET ADMIN	1,305.07
TOTAL ALL BRANCHES	18,649.17

Exhibits 21 and 22 as "Less Deduct Items" is an error which materially affects a claim. The error in this sample occurs in the line entry for the patient named Kalerg. Column T, Amount Paid for Principle Procedure, is shown as $131. The OCHAMPUS Edit Error Program automatically searches the files for a determination of which figure is correct and calculates the correct amount, in this case $64.80.

A "Soft" edit error, on the other hand, does not materially affect the claim. Examples of soft errors are shown in Exhibit 23. This sample soft edit error list is taken from a physician's claims tape. The code "37 I" is defined as an invalid procedure code in Column R. Exhibit 24, the legend for Physician's Records, is included to permit easier reading of Exhibits 22 and 23.

All edit errors are returned to the contractor for correction via a standard form letter which explains the effect of hard and soft errors and contains direction to the contractor on procedures to follow in correcting and resubmitting the error claims. This form letter is shown in Exhibit 25. It should be noted that less than 10 percent of all claims that are processed by OCHAMPUS result in an edit error list.

After the processed Voucher Listings have been compared with the Control Listings, a voucher clerk prepares a CHAMPUS Form 197, Contractor Reimbursement Worksheet. This form is shown in Exhibit 26. The Voucher Number block may contain more than one Voucher Number, but each number can be readily

EXHIBIT 21

MC50H

EDIT ERROR LIST FOR 02 VOUCHER
VOUCHER = 751919 INVOICE = 000609

DAY MO YR
16/04/75

VOUCHER TOTALS	GOVT COST BILLED	62,194.19	CLAIMS BILLED	937
	LESS DEDUCT ITEMS	64.80	CLAIMS DEDUCT	1
	TOTAL REIMBURSEMENT	62,129.39	TOTAL CLAIMS	936

EXHIBIT 22

MC50H EDIT ERROR LIST FOR 02 PHYSICIAN DAY MO YR
VOUCHER = 751919 INVOICE = 000609 16/04/75

A	BC	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z
HARVEY	B	35	1	3	456543443 37 I	2	1			722	02	56945	72	25	610	00421	00	0045	0045	0045	00900	003600	000000	7
JAEGER	JA	25	1	3	117424244 37 I	2	1			722	02	56945	72	94	233	00421	00	0045	0045	0045	00900	003600	000000	7
HARRIS	SJ	25	1	3	406749774 37 I	2	1			720	02	2	72	84	796	07421	00	0045	0045	0110	02200	000000	008800	7
ERVIN	HL	68	4		440321945 04 O	4	2	1		729	02	56797	72	25	401	09000	02	0011	0011	0029	00725	002175	000000	P
PLYLER	JA	69	1		432662774 04 O	1	2	1		729	02	2	72	44	692	09000	02	0011	0011	0020	00492	000000	001475	P
STRAIN	P	65	1		356038782 04 O	2	2	1		720	02	2	72	25	847	09028	00	0007	0007	0101	02525	000000	007575	P
KALERG	RJ	27	1	3	512386837 32 R	1	3			717	02	10067	73	15	796	09099	00	0031	0131	0131	06620	006480	000000	7

PROCEDURE CODE 99200 CLAIM COUNT 0

PROGRAM TOTALS	GOVT COST BILLED	56,798.90	CLAIMS BILLED	768
	LESS DEDUCT ITEMS	64.80	CLAIMS DEDUCT	1
	TOTAL REIMBURSEMENT	56,734.10	TOTAL CLAIMS	767

EXHIBIT 23

MC50H — EDIT ERROR LIST FOR 14 PHYSICIAN — DAY MC YR — PAGE CCCC5
VOUCHER = 751816 INVOICE = CC0216 01/04/75

A	BC	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	1
KENT	HL	01	3	1	253663435 37 I	1	1			515	14	004466	C1	15	485	00220	CO	C03C	0030	0110	00000	011000	000000	7	
JEBSCN	RR	22	1	1	478727983 37 I	1	1			527	14	CC8862	C1	84	3CC	00220	CO	CC25	0025	0712	00000	071200	000000	7	
JESS	TA	02	3	1	478622803 37 I	1	1			514	14	0013C0	C1	25	CC9	00220	00	C025	0025	0122	00000	012200	000000	7	
HCLLIC	MJ	16	3	2	478341375 37 I	2	2	1	503	14	C99893	C1	54	945	00222	CO	C250	0250	0925	23125	000000	069375		7	
CARPER	SP	39	1		230241801 37 I	4	2	1	502	14	C99893	C1	84	47C	00250	CO	C155	0155	0155	03875	000000	011625		7	
HCLLEY	BK	18	1	1	478687885 37 I	4	1			5CE	14	C06433	C1	64	599	00250	CO	C061	0061	0061	00000	006075	000000	7	
FCRTIE	RC	45	4		526308709 37 I	2	2	1	501	14	001180	C1	64	532	00250	CO	CC6C	0060	0160	04000	012000	000000		7	
CHRIST	PA	39	1	2	485328287 37 I	4	1			522	14	CC2455	C1	25	429	00250	CO	CC50	0050	0050	00000	005000	000000	7	
STEVEN	DE	35	1	1	483520846 37 I	1	1			526	14	001464	C4	42	5CC	00250	00	CC35	0035	0035	00000	003500	000000	7	
SIRCNE	DE	03	2	3	C03323514 37 I	1	1			528	14	06C1C4	73	15	92C	00250	01	C043	0043	0068	03920	002880	000000	7	
RCBERT	RD	00	2	2	484680167 37 I	1	1			525	14	005137	C1	64	62C	00285	CO	CC3C	0030	0030	00000	003000	000000	7	
KLEIN	JM	00	3	1	481464862 37 1	4	1			52C	14	0016C8	C1	15	62C	00285	CO	CC25	0025	0025	00000	002500	C00000	7	
WEBSTE	AC	00	2	1	481748192 37 I	4	1			511	14	C05525	C1	25	62C	00285	CO	CC25	0025	0025	00000	002500	000000	7	
MARCLA	CD	00	3	1	399505533 37 I	2	1			527	14	006E54	C1	24	62C	00285	00	CC25	0025	0025	00000	002500	000000	7	
CLLMAN	GE	16	3		484348024 37 I	4	2	1	506	14	001888	51	15	CC9	00600	05	CC1C	0010	0037	00925	002775	000000	7		
RLBNER	CR	37	1	2	481464342 37 I	1	1			505	14	C99893	51	-4	62E	0C600	C2	CC25	0025	0040	00880	000000	003120	7	
SLCAN	WE	63	4		484326762 37 1	4	2	2	503	14	CC3E14	04	-4	532	00610	CO	CC75	0075	0075	01875	005625	000000	7		

EXHIBIT 24

LEGEND FOR PHYSICIAN RECORDS

A - Patient's Last Name
B - First Initial
C - Second Initial
D - Age of Patient
E - Relationship
F - Basis of Care
G - Service Number
H - Grade or Rank
I - Branch of Service
J - Status
K - Certification
L - Zip Code
M - State Code
N - Location of Source of Care
O - Patient Status
P - To Date (Month and Year)
Q - Diagnosis
R - Principal Procedure
S - Number of Outpatient Visits
T - Charges for Principal Procedure
U - Amount Paid for Principal Procedure
V - Total Amount Charged for All Services
W - Paid by or Due from Patient
X - Due from Government to Source of Care
Y - Due Patient or Sponsor Reimbursement
Z - Claim Number

EXHIBIT 25

DEPARTMENT OF DEFENSE

OFFICE FOR THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES

DENVER, COLORADO 80240

CH. 19

RE: OCHAMPUS Voucher #

Dear

Inclosed is a machine listing of rejected and unrejected (hard and soft) errors found by the application of the OCHAMPUS Editing Procedures as outlined in the appropriate Appendix, as revised.

Rejected (hard) errors have been deleted from payment of your Invoice No._____ as indicated:

STATE	CLAIMS			AMOUNTS		
	PHYS	DRUG	HDCP	PHYS	DRUG	HDCP

Please correct these rejected records and resubmit them on a future invoice. Do not resubmit these records as adjustments, since a claim rate has not been paid for these rejected claims.

Unrejected (soft) errors may also appear on the attached list. These records have not been rejected, but require correction. Please correct these records and resubmit them on a future invoice as adjustments. It is important that these soft errors be resubmitted as adjustments, since a claim rate has already been paid on these unrejected claims. Unrejected claims may include credit items. Credit items will never delete as hard errors, since a credit deletion could result in a voucher total greater than the invoiced amount.

Sincerely,

Incl.
Error Edit Listing

REBA B. RANSOM
Chief, Finance and Accounting Division

CONTRACTOR REIMBURSEMENT WORKSHEET – PROFESSIONAL COST LIQUIDATION & ADMINISTRATIVE COSTS

1. VOUCHER NO.

2. MAKE PAYABLE TO:

3. PP #			
		Certified Invoice Attached Certified Invoice Attached Certified Invoice Attached	$
		(For Period _____ thru _____) For Payment to Civilian Sources for Health and Medical Benefits (_____ Claims)	
		Certified Invoice Attached Certified Invoice Attached Certified Invoice Attached	
		Claims at $ _____ each	
			$
		Less _____ PP No. _____ (Vou No. _____) dtd _____ Less _____ PP No. _____ (Vou No. _____) dtd _____ Less _____ PP No. _____ (Vou No. _____) dtd _____ Less _____ PP No. _____ (Vou No. _____) dtd _____	
		21 42020 06–6030 P840000-2572 (FIC 841214.12100.199) SO5114 Army.	
		Amount Verified	$

CHAMPUS FORM 9 AUG 73 197

traced back to the original request for advancement of funds. To explain further, refer to the Voucher Number 75-1818 on previous exhibits and in the discussion above. When the SF 1034 was prepared for the advance funds, this number appeared as 75-1818(I). On the Voucher Transmittal and on the Form 197 now being prepared the number appears as 75-1818(II). If one assumes that the invoice contained the Hard Edit Error in Exhibit 22, the same Voucher Number will appear on another Form 197 as 75-1818(III) when the edit error is resubmitted for payment. Another method of cross-reference on the Form 197 is the block labeled "PP#" in which the partial payment number from the funds advanced voucher and the Routing and Transmittal Slip is entered.

Within the main portion of the Form 197 the top three entries titled "Certified Invoices Attached" are suffixed by a letter - P, D, H, etc. - depending on whether the category of claims is for Physicians, Drugs, Hospital, or so forth. The dollar amounts of the claims are entered in the dollar column. Deduct items from Hard Edit Errors are subtracted from the claims costs to arrive at a net total of professional costs.

The "Certified Invoices Attached" section in the middle of the form is used to account for administrative costs as computed on the Summary by Branch section of the Voucher Listing shown in Exhibit 20, above. As in the professional costs section of the form, deductions for Hard Edit Error

claims are made, that is, the claim rate times the number of rejected claims is deducted from the total administrative costs shown on the Summary by Branch.

C. ACCOUNTING PROCEDURES

After CHAMPUS Form 197 is completed, it is sent to an accounting technician who verifies the figures against ledger entries for the advancement of funds. This particular procedure is time consuming as the accounts are listed by Fiscal Year, by Professional Cost categories, by Administrative Cost categories, and by Direct and Indirect Cost categories for each branch of service. These accounts are listed on an accounting sheet which is approximately 48 inches long. All entries on this spread sheet are made manually and all columns must be totaled, balanced, and cross footed daily.

When the above procedures are completed, the information is posted to a Miscellaneous Obligation Document, DA Form 3717. This form is shown in Exhibit 27. The date used on this form is the next working day's date. The description is a four digit internally generated code representing the branch of service. The codes currently in use are:

ARMY - 6025	PHS - 6028
NAVY - 6026	VET ADMIN - 6029
AIR FORCE - 6027	

Column 3 is the amount in the appropriation for the branch of service, column 6 is the total disbursed for that day, and column 7 is the unliquidated balance of the appropriation.

EXHIBIT 27

MISCELLANEOUS OBLIGATION DOCUMENT
FOR USE OF THIS FORM, SEE AR 37-108, THE PROPONENT AGENCY IS OFFICE OF THE COMPTROLLER OF THE ARMY

Use reverse side for continuation of partial payment record.

MISCELLANEOUS OBLIGATION DOCU NR	DATE PREPARED

INSTALLATION	ACCOUNTING CLASSIFICATION
	APPROVED BY
PREPARED BY *(Signature and title)*	

DESCRIPTION	AMOUNT

PARTIAL PAYMENT RECORD

NAME OF VENDOR OR CONTRACTOR

CONTRACT OR PURCHASE ORDER NUMBER

DATE 1	DESCRIPTION 2	OBLIGATION 3	ACCRUED EXPENDITURE 4	ACCOUNTS PAYABLE BALANCE 5	DISBURSEMENT 6	*(Check appropriate box)* ☐ UNLIQUIDATED ☐ UNDELIVERED BALANCE 7

The sum of the figures in columns 6 and 7 must equal the balance shown in column 3.

The process is completed when the above data is entered into the computer from the appropriate Accounting Coding Sheet, a form used primarily for the computer keypunch section. At the end of each month all accounting reports generated by the computer are checked against the accounts in the several ledgers and manually balanced against the FAMC Disbursing Officer's Report. In case of differences the Disbursing Officer's Report is considered the correct figure. In order not to have to go back through the 400 plus vouchers processed in an average month, the Disbursing Officer furnishes OCHAMPUS with a daily Disbursing Officer's Report. An additional check is made to make certain that the ledger figures are what was actually fed into the OCHAMPUS computer.

The Finance and Accounting Division receives at the end of each month all of the usual accounting reports, such as the Trial Balance of Accounts, a Consolidated Allotment Report, a Status of Funds Report, a Status of Reimbursements Report, a Current Month's Disbursements Report, a Cumulative Disbursements Reports, and a Report of Unliquidated Obligations. The Status of Reimbursements Report pertains to funds owed to OCHAMPUS by the Public Health Service and the Veterans Administration for which direct reimbursement authority was received from the Secretary of Defense at the time the approved budget for OCHAMPUS was received. These funds are

billed to the respective agencies for the amount of professional claims costs and administrative costs on a monthly basis. A Standard Form 1080, shown in Exhibit 28, is used for these billings. Because there is the direct reimbursement authority, the agencies are not required to issue a Reimbursable Work Order or other similar document as is required in nearly all other reimbursable instances.

The Finance and Accounting Division also receives one special report each month. This is the Finance and Accounting Distribution List. This report provides the professional claims costs by category of claim, by administrative costs, by direct and indirect costs for each branch of service by fiscal year and by state. Thus, they can cite, for example, that the total costs for Fiscal Year 1974 for Physician's claims and other costs that were incurred by Navy beneficiaries in the State of Florida amounted to $1,111.23, or whatever the true sum might be.

Standard Form 1080
Revised May 1970
2 Treasury FRM 2500
1080-106-03

VOUCHER FOR TRANSFERS BETWEEN APPROPRIATIONS AND/OR FUNDS

VOUCHER NO.

SCHEDULE NO.

BILL NO.

PAID BY

Department, establishment, bureau, or office billing

Department, establishment, bureau, or office billed

ORDER NO.	DATE OF DELIVERY	ARTICLES OR SERVICES	QUANTITY	UNIT PRICE COST	UNIT PRICE PER	AMOUNT DOLLARS AND CENTS
					TOTAL,	

Remittance in payment hereof should be sent to—

ACCOUNTING CLASSIFICATION—*Billing Office*

Appropriation Symbol and Subhead	Object Class	Bureau Cont. and Suballot. No.	Auth. Acctg. Activity	Type	Property Acctg. Activity	Cost Code	Amount

CERTIFICATE OF OFFICE BILLED

I certify that the above articles were received and accepted or the services performed as stated and should be charged to the appropriation(s) and/or fund(s) as indicated below; or that the advance payment requested is approved and should be paid as indicated.

(Authorized administrative or certifying officer)

(Date)

(Title)

ACCOUNTING CLASSIFICATION—*Office Billed*

Paid by Check No.

CONCLUSIONS

In the chapter on the OCHAMPUS organization we provided a picture of the administrative process presently used to manage the complex program. The description of claims processing provides an idea of how program contractors, providers and administrators interact with the beneficiaries and the health care providers.

Considerable thought has been given to having OCHAMPUS perform all of the claims processing actions presently accomplished by Blue Cross, Mutual of Omaha and the several Blue Shield and State Medical Societies. On the surface this suggestion seems feasible but further consideration indicates it may be impracticable. If OCHAMPUS were to process all claims, their present computer facilities would be woefully inadequate. To expand their facilities would require several million dollars. Another factor is the number of persons required to review all the claims. Regardless of how sophisticated a computer setup is used, people are still needed to do the manual phases of the processing. The several CHAMPUS fiscal intermediaries process over 265,000 claims per month. To do this approximately 670 persons are employed by these contractors. Still another factor is the CHAMPUS requirement of maintaining a personal history file. These files, even when on computer tape, occupy a large amount of space. This would mean that OCHAMPUS would have to expand its storage area, which in time, would mean additional investment in equipment

and buildings as well as more people.

Other factors, such as maintenance of provider profiles and claims activity and audit files, would take more space, equipment and personnel. These files would probably not be as comprehensive nor as accurate as the ones currently maintained by fiscal intermediaries. For example, Blue Shield of California maintains a provider profile on every physician in the State of California. This profile allows them to accurately determine area "customary" fees. If OCHAMPUS maintained such a profile system, it would be comprised of only those providers who accepted CHAMPUS patients and thus the area "customary" fees would be composed of a smaller number of providers and would, most likely, be not as accurate.

Other methods of cutting program costs are being studied by several groups including the Surgeon Generals, the Assistant Secretary of Defense and the Office of Management and Budget. These studies are primarily concerned with the better management of the program. It is our opinion, that the program's management, at least at the OCHAMPUS level, is good. The staff at OCHAMPUS is concerned about the costs and is striving to find ways of reducing them. The introduction of the Word Processing System has reduced the number of secretarial persons needed to prepare reports. They are in the process of computerizing the Finance and Accounting Division. This step will serve to reduce the contractor

invoice processing time. The Contract Administration Division is constantly monitoring claims processing activities of the contractors and working with them in an effort to reduce the claims backlog. The Liaison Division is striving to better educate the beneficiaries as to allowable benefits of the program.

That this program is complex cannot be denied. It has three management levels, i.e., ASD, OCHAMPUS, and fiscal intermediaries that do not always know what each other's needs are. The amount of paperwork necessary to "manage" this program is, although considerable in bulk, not completely unmanageable. It would seem that the CHAMPUS Program, as it is presently structured, does little in allowing the beneficiary a voice in its operation. It is true that the beneficiary does have the freedom of choice to go to a military or a civilian facility but once that choice is made, he has no further voice in the program's operation. There is nothing in the CHAMPUS Program that encourages the beneficiary to shop around for the best available care at the lowest price. This facet of the program's management could use more emphasis.

REFERENCES

1. Deputy Secretary of Defense Memorandum, Subject: CHAMPUS, 4 December 1974.

2. Department of Defense, Office For Civilian Health and Medical Program of the Uniformed Services, Organization and Functions Manual, Denver, Colorado, 1 April 1974.

3. OCHAMPUS, CHAMPUS Program Manual, Denver, Colorado, no date.

4. William W. Hall, Jr., Supervisor, CHAMPUS/CHAMPVA Department, Blue Cross of Northern California, personal letter, 13 March 1975.

5. J. J. Wrabetz, Assistant Vice President, CHAMPUS, Mutual of Omaha Insurance Company, Omaha, Nebraska, personal letter, 28 March 1975.

6. Mel Shiltz, Assistant Manager, CHAMPUS/CHAMPVA, Blue Shield of California, interview conducted during visit to Blue Shield offices, 8 February 1975.

7. Ms. Rheba Ransom, Chief, Finance and Accounting Division, OCHAMPUS, Denver, Colorado, interview conducted during visit to OCHAMPUS offices, 24-25 April 1975.

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